Round Table

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The St Gallen point of view: How do you select treatment for "average/high risk" node-negative patients?

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Adjuvant systemic therapy reduces the risk of relapse and death after local treatment for early breast cancer. All such treatments carry some morbidity. The benefits are calculable, but less easily guaranteed or expressed to an individual patient.

Three fundamental questions must be addressed. The first two ' is there a benefit? and if so how large is that benefit? 'are essentially statistical and best answered from the rich resources of the available Oxford Overviews. The third question 'is treatment worthwhile for a particular patient? 'is more subjective. The answer must involve negotiation between doctor and patient, with explicit attempts to describe the degree of risk the patient would face in the absence of treatment, and the benefit reasonably to be expected from each of the available treatment options.

Since the last Oxford Overview in September 2000, there have been two major international consensus meetings which attempted to provide guidance to patients and doctors. At both meetings, it was recognised that patients exhibit a spectrum of acceptance, with many willing to undergo moderately morbid adjuvant therapy for very small gains in survival.

The St. Gallen Consensus meeting proposed a simplified two-category classification of risk for patients with node negative breast cancer. Patients with all of the favourable features (pT $\leq$ 2 cm; receptor-positive; age $\geq$ 35 yr; histologic and/or nuclear grade I) were regarded as at 'minimal/low' risk, while all other patients were classified as 'average/high' risk. Treatment advised for average/high risk patients was primarily dependent on tumour receptor status. Chemotherapy was the only option advised for patients with receptor-negative disease, while at least one of a variety of endocrine therapies with or without chemotherapy was considered important for those with receptor-positive disease.

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The German consensus

Abstract not received.

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The UK view point

Abstract not received.

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The San Antonio view point

Abstract not received.

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Introduction: Dimension and fascination of complimentary and alternative medicine in oncology

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Despite substantial progress of scientific clinical oncology (SCO), the fascination of alternative and especially complimentary cancer medicine (CAM) has not at all declined during the past 20 years. In the contrary, at least in Europe, CAM is more popular than ever with the patients and their social environment. Between 40–70% of cancer patients make use of CAM, whereby the methods used vary greatly between countries and regions, according to socio-cultural background. What are the reasons for this situation, and how should academic oncology deal with it?

1. CAM - in contrast to SCO and academic medicine in general – did greatly profit from the potential of modern advertisement technology and from liberalisation of health and communication laws in many countries. Qualitatively uncontrolled internet promotion of dubious, unproven recommendations are a welcome source of false hope for despaired patients.

2. CAM - in contrast to SCO – has been successfull in linking to the modern "biological" health movement, and to the "green" and antiestablisment scene in health-politics with its anti-hormonal, anti-chemical and anti-radiation expressions.

3. CAM - also in contrast to SCO – offers to patients, overwhelmed by the impact of surgery, chemo- and radiotherapy imposed on them by professional "external" staff, offers to them a system of helpful active self-involvement in bio-logical (yet ineffective) treatment plans.

4. CAM - in sharp contrast to SCO – tends to maintain a certain aura of mysticism and likes to operate at the border of legality and martyrium, which greatly increases the attraction for a certain fraction of uncritical cancer patients.

5. SCO should recognise these facts and better learn how deal with these attributes of CAM in a more clever and relaxed attitude, discussing these problems more openly with respective patients.

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The role of complementary and alternative medicine in cancer

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Complementary and Alternative Medicine (CAM) is amazingly popular; this applies to the general population and even more so to defined patient groups. In particular, cancer patients often try CAM [1]. Their motivation is complex but 'leaving no stone unturned' is probably one of the most powerful reasons. It is obvious that cancer patients are amongst the most vulnerable of all CAM users. Therefore we need to critically analyse how effective CAM is for this indication. In an attempt to answer this question it is helpful to differentiate between CAM used as a cure or prevention of cancer and CAM used as a means of caring for cancer patients. Numerous remedies are advocated as CAM cancer cures, e.g.: 714Y, Di Bella therapy, Essiac, hydralazine sulphate, mistletoe, shark cartilage, special diets, thymus therapy. None of these treatments has been shown to be effective beyond reasonable doubt [2]. Some strategies advocated in CAM may offer hope in terms of cancer prevention: allium vegetables, ginseng, green tea, vegetarian diets. Several CAM treatment modalities are used in palliative care. Such therapies include: acupuncture, aromatherapy, autogenic training, hypnotherapy, massage, reflexology, relaxation, and many other forms of CAM. With such palliative treatments one might argue that if patients feel better, why not use them? While this may be an ethical approach for patients we care for today, we also have an obligation to tomorrow's patients to determine which of these treatments are better and more cost effective than other therapeutic options. The only way to do this is through adequately designed investigations. With all CAM we must also critically evaluate the complex safety issue. They relate both to potential direct harm (e.g. administration of a toxic substance) and potential indirect harm (e.g. delay of an effective orthodox therapy). The ultimate question is, which form of CAM is doing more good than harm? Because our present knowledge is incomplete, we are often not in a good position to provide conclusive answers. It follows that more rigorous research has to be initiated (and funded) in the area of CAM for cancer.

References

[1] Ernst E, Cassileth BR. The Prevalence of Complementary/Alternative Medicine in Cancer. *Cancer* 1998; **83:** 777–782

[2] Ernst E, Cassileth BR. How Useful are Unconventional Cancer Treatments? *Eur J Cancer* 1999; **35:** 1608–1613