Str.—May we, through the courtesy of your columns, inform surgeons, radiotherapists and other interested doctors of a new clinical trial which will shortly be launched?

This will be a nationwide study, supported by the Cancer Research Campaign, in which the main objective will be to compare two types of treatment. Patients will be prospectively randomized to undergo either simple mastectomy with axillary node sampling and postoperative radiotherapy, or local excision of tumour ("lumpectomy"), also with axillary nodes sampling and radical radiotherapy treatment. This study protocol provides for radiotherapy in similar dosage to both groups of patients, so that the surgical treatment will be the only variable. Although the survival of these patients will of course be of the greatest importance, the trial design will also allow us to assess the local recurrence rate, the cosmetic results of treatment, and (in a selected group of patients) the psychological sequelae of the two methods of treatment.

In order for this study to have the power to discriminate between small but possibly important differences in these two methods of treatment, it will be necessary to include a large number of patients. We hope to study some 2000 women. We therefore invite all interested clinicians to participate in this trial and if you wish to receive a protocol, please write to Mrs J. Houghton at the address below.

Our motivation has been a genuine uncertainty on the part of this Working Party as to whether local excision with radical radiotherapy offers a realistic and safe alternative to mastectomy, and we feel that this study should make a major contribution towards answering this critical question.

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POSTCHEMOTHERAPY STAGING LAPAROTOMY IN HODGKIN'S DISEASE

Str.—Barr et al. (1982) recently concluded in this journal that a postchemotherapy staging laparotomy (SL) in Hodgkin's disease is not recommended either for patients in clinical remission or for patients with evidence of relapsed disease, regardless of the stage of disease.

We agree that SL is of little value for carefully-staged patients with CS I and II disease having been initially treated with polychemotherapy instead of radiotherapy.

On the other side our own experience supports the conception that SL might be justified furthermore in patients with CS IIIB and IVB disease to detect residual tumor not sufficiently eradicated by polychemotherapy (Sutcliffe & Stansfield, 1978).

During the 10-year period 1972 to 1981 56/88 patients (64%) with stage IIIB (n=46) or IVB (n=10) have had a postprimary staging laparotomy (PPSL) (Kuse et al., 1979) within 2 months after the completion of at least 6 cycles of COPP- or COPP+ABVD-polychemotherapy. The median age was 32 and the range, 15–60 years. In 27 cases PPSL
was not performed on behalf of medical reasons, refusal, or progression of disease. Five additional patients had a positive splenectomy before therapy.

Forty-eight out of 56 patients were considered to be in clinical remission after chemotherapy. Nine of them (19%) showed active disease in spleens of normal size at laparotomy. Further polychemo- or radiotherapy could be started early and 6/9 patients reached a long-lasting complete remission. All 8 cases suspected for residual disease on behalf of elevated sedimentation rate showed active disease in normal sized spleens (n=5) or in paraaortic lymph nodes (n=3). Only 2 of them reached a complete remission by further management.

Because non-invasive methods including computerized tomography may fail in restaging of Hodgkin’s disease and make the assessment of clinical remission after chemotherapy in stage IIIB and IVB patients difficult, PPSL might be of considerable value and enhance the probability of long-term survival for this former poor-risk group (Kuse et al., 1981).

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