Overall 38% believed air exposure during surgery would cause a tumor to spread. By race, 61% of African Americans and 29% of White respondents agreed with this belief. In univariate analysis, this belief was also associated with lower income and education levels, but in multivariate analysis, race was the only factor significantly associated with this concern about surgery.

Nineteen percent of African Americans and 5% of Whites said they would refuse lung surgery based on the myth. Some 14% of African Americans and 5% of Whites would stick to their belief even if their doctors told them it was false.

Few people remembered where they first heard of the notion that surgery causes lung cancer to spread; some named “the gossip mill.” What many people did remember were unfavorable medical outcomes for loved ones with cancer.

“The reality is that people come in very late in the disease and a few months later they die,” explained Harold Freeman, MD, of North General Hospital in New York City and an expert on racial disparities in cancer.

“People who believe myths have a life experience that supports their beliefs,” he continued, “and if people’s relatives and friends are being operated on and dying, that’s a strong personal experience.”

Margolis speculates that past experiences with poor surgical or perioperative care could play a role, as well as “the legacy of racial discrimination against African Americans, mistrust and disenfranchisement from the current health care system.”

Overall, the outlook for surviving localized lung cancer has improved somewhat, largely due to better surgical techniques. The five-year survival rate for White patients at this stage is 49%. But African Americans don’t do as well; only 43% survive five years or longer after diagnosis.

In his journal article, Margolis cites a recent study of elderly patients with localized lung cancer (based on the linked SEER-Medicare database) that found a 13% lower rate of surgery and an 8% lower five-year survival rate for African Americans compared with Whites.

Freeman says doctors and patients must both make changes so false beliefs don’t prevent patients from pursuing the best treatment. “The key to this is that we have to ask physicians to be very sensitive and understanding and open about the myths or beliefs that people share with us,” he said.

“There are reasons for patient’s beliefs,” said Freeman.

“Doctors have to take more time and try to bring some logic to the issue without insulting the dignity of the person,” he continued. “If all cancers touched by air did spread quickly, you could logically assume that all people whose cancers are treated with surgery would die. And that’s clearly not the case.”

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LETROZOLE CUTS BREAST CANCER RECURRENCES

Breast cancer survivors may have a new and improved option for adjuvant hormonal therapy, according to a study that was stopped early because of its promising findings. The aromatase inhibitor letrozole (Femara), when started within three months after completing five years of adjuvant therapy with tamoxifen cut breast cancer recurrences by almost half, in an international study of 5,187 postmenopausal women.

Aromatase inhibitors, first approved for the treatment of recurrent breast cancer in December 2000, reduce estrogen levels in postmenopausal women by inhibiting peripheral conversion of androgens into estrogens. The study was published in October on the Web site of the New England Journal of Medicine and appeared in the November 6 print issue (2003; 349:1793–1802).
Out of the 5,187 women in the study, 207 had cancer recurrences or new primaries—75 in the group taking letrozole and 132 in the placebo group. From these results, the researchers estimated that the women on letrozole would have a four-year disease-free survival rate of 93%, compared with 87% for women in the placebo group. Although the breast cancer death rate was twice as high in the placebo group as in the letrozole group, this difference was not statistically significant.

Lead author Paul Goss, MD, PhD, of Princess Margaret Hospital in Toronto and colleagues from several North American and European cancer centers designed the study to determine the efficacy of five years of letrozole. Before this report, there hasn’t been any treatment that has been proven to ward off recurrence after completing five years of tamoxifen. Goss and colleagues created the study to address that problem.

“Over 50% of recurrences from breast cancer occur in the long-term after diagnosis, and that hangs like a black cloud over survivors and their families,” he said.

However, the first interim data analysis (with a median follow-up of 2.4 years) found that the risk of a local recurrence, metastatic recurrence, or a new contralateral primary breast cancer was 43% lower for the women on letrozole. Because the interim results exceeded thresholds specified in the initial design of the study, the data and safety monitoring committee advised that the study be stopped and the women in the placebo arm be offered letrozole. In fact, the trial’s consent form included a statement assuring participants that they would be informed if such thresholds were exceeded and that women receiving a placebo would have an opportunity to switch to letrozole.

One of the problems with stopping the study early, however, is that researchers will no longer be able to determine the optimal duration of treatment with letrozole, they may be unable to tell whether letrozole has a statistically significant impact on overall survival, and they will be less able to evaluate the drug’s long-term safety. Researchers will continue to follow the study participants to get answers about long-term use, but will not have a placebo group for comparison.

New cases of osteoporosis were very slightly more frequent in the group taking letrozole. The researchers recommended women on letrozole also take calcium and vitamin D, and have bone density tests, until the long-term effects of letrozole on bone are better understood. They also noted that studies are underway to evaluate whether bisphosphonates can maintain bone density in women also receiving aromatase inhibitors.

Other side effects of letrozole were mild and included low-grade hot flashes, arthritis, arthralgia, and myalgia.

Patricia Ganz, MD, of the Jonsson Cancer Center and Professor, Schools of Medicine and Public Health, University of California, Los Angeles said the trial was well designed and well executed.

While noting that letrozole reduced the likelihood of recurrence in both node-negative and node-positive patients, she said the risk of competing morbidities like osteoporosis and fracture may outweigh the benefits of the therapy in some very low risk patients.

“Unfortunately, the early termination of the trial limits the conclusions we can make about the magnitude of long-term survival benefit, as well as the risks of side effects,” she said. “Although it would be tempting to recommend letrozole to all women who have completed adjuvant tamoxifen, even if some time period has elapsed, we can only make clinical recommendations for patients who fit the eligibility and treatment plan associated with this trial.”

Ganz said that overall, this trial and other recent trials such as the Arimidex, Tamoxifen, Alone or in Combination trial provide ongoing evidence for the pivotal role of therapies that target the estrogen receptor in modulating the
recurrence of previously diagnosed cancer and the development of new cancers in the contralateral breast.

“We are fortunate to have a broad menu of endocrine therapies to apply in early stage breast cancer,” she said, “and the strategic questions for the future will be the maximization of benefit with minimization of acute and late side effects.”

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