



## Letters

# Management of women with early breast cancer

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## Affluence seems to affect management of breast cancer

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EDITOR—Macleod et al in their article present a wealth of data on the management of women with early breast cancer from affluent and deprived areas in Glasgow.<sup>1</sup> It would have been informative to examine also a wider range of indicators of quality of care, such as those identified by the Clinical Outcomes Group<sup>2</sup> and the British Association of Surgical Oncology,<sup>3</sup> including access to specialist teams dealing with more than 100 new cases per year, access to diagnostic testing by triple assessment on the same day, and participation in clinical trials.

The lower rates of axillary sampling found in the deprived group may not be, as Macleod et al impute, solely an artefact due to unusual practice in a single hospital. In our work on monitoring the quality of care for breast cancer in North Thames health region,<sup>4</sup> we have found that surgeons use the terms “sampling” and “clearance” rather loosely when recording surgical procedures in the axilla. It is more informative to examine the number of nodes excised—poor practice being excision of too few nodes—to decide on the management of the patient. The comparison of the number of nodes sampled avoids possible bias due to association between hospital terminology and socioeconomic status of the patient.

Although the median wait from referral by the general practitioner to first visit to the clinic was only one day longer for deprived women, there was a distributional shift. Among deprived women, the 25% who waited longest waited 20 days or more. The corresponding figure in the affluent group was only 13 days. Like the one day difference in median waiting time, a one week difference in the 75th centile of waiting time may in itself be of limited relevance to the clinical outcome. If these differences are, however, indicative of other aspects of the quality of care, this may potentially explain part of the known socioeconomic gradient in survival.<sup>5</sup> Compared with the national standard of a maximum two week

waiting time, 25% of affluent women, and some 35% of deprived women exceed this standard. Perhaps a closer look at these data might reveal that all is not as equitable as Macleod et al suggest?

## References

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## Definitions, outcomes, and analysis need clarifying

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EDITOR—In their article on the management of early breast cancer in women with different socioeconomic status, Macleod et al raised some useful points, but we think that the situation is not as straightforward as suggested.<sup>1</sup>

The aim of the study outlined in the abstract was to investigate whether poorer survival of deprived women with breast cancer is related to NHS care. But survival estimates were not attempted, even though the cohort used was treated in 1992-3. We must also agree with Robinson that the outcome measures used to indicate quality of care are not necessarily the most relevant.<sup>2</sup> Waiting times from referral to treatment are perhaps less useful in the context of deprivation than delay in presentation to the general practitioner and delay in the decision to refer women with breast cancer, but this was not investigated. The study concentrated on differences in axillary surgery, yet nodal surgery is often inaccurately described as either sampling or clearance. No data are provided on the number of nodes taken, a better indicator of adequate surgery.

There was no definition of the size or stage of the early cancer group. If patients with locally advanced or metastatic cancer are included, analysis shows a statistically significant increased risk of being diagnosed with advanced cancer for those from deprived areas (relative risk 2.4; 95% confidence interval 1.2 to 4.7;  $P=0.006$ ).

Finally, the paper does not make clear whether screen detected cases were included in the analysis. The inclusion of screened cases can mask differences in socioeconomic status with respect to breast cancer survival, and separating screened cases from symptomatic ones may show important differences between the deprived and affluent groups.

## References

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## New strategies are needed to address inequalities

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EDITOR—With the increasing pressure of health service funding to focus on rewarding performance indices, the paper by Macleod et al is particularly salutary in its finding that the difference in outcome was not due to inequality of access to care.<sup>1</sup> Further support for this view is provided by comparing the outcome for breast and prostate cancer in east London and neighbouring areas from which patients are referred.

Previous reports from the Thames Cancer registry data showed a substantial difference in 5 year survival in patients with breast cancer treated in 1986-7 in east London compared with those treated in other areas of the Thames region.<sup>2</sup> Review of records held by the registry on patients with breast and prostate cancer treated by the Royal London and St Bartholomew's Hospital during the same period and comparison with the total Thames Registry data showed a similar disparity in survival (table).

Breast cancer		

District of residence	Royal Hospitals Trust 2 year survival <sup>†</sup>	Thames Cancer Registry 1986-7, 5 year survival	Prostate cancer: Royal Hospitals Trust 2 year survival <sup>†</sup>
Inner east London	77 (163)	62 (83)	47 (29)
Outer east London	82 (151)	69 (83)	58 (28)
West London	87 (53)	72 (83)	25 (8)
Outside M25 motorway	90 (17)	83 (83)	75 (4)

- \* J Bell, personal communication.

**Treatment of breast and prostate cancer at Royal Hospitals Trust, 1991. Values are percentages (base numbers)**

Such differences do not preclude clinician related factors in outcome, but they make funding on the basis of outcome extremely inequitable. In the context of the current debate on reform of the NHS, there is clearly a need to identify strategies that address these inequalities. Whereas recent data provide doubt about the value of vitamin supplementation in well nourished people, some data show a bell shaped curve of effect, with the benefit of supplementation seen only in people with low values.<sup>3</sup> This highlights the need for more attention to be paid to developing assays of poor nutritional status that could be applied easily by general practitioners to patients attending for routine minor healthcare problems or in schools. Given the high incidence of tuberculosis in the same areas, these approaches could result in further gains. An alternative might be to re-establish population based supplementation such as providing milk and orange juice in schools regardless of whether health indices are poor because it might also benefit educational development.

## Footnotes

- I thank the Thames Cancer Registry for providing patient data.

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# Authors' reply

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EDITOR—We agree with Robinson et al that it would have been useful to examine a wider range of quality indicators. The design of our study, however, predated the publication of the two reports that they cite. As these indicators are now the basis of prospective audit being carried out throughout Scotland by the Scottish Cancer Therapy Network, it will be possible to relate such indicators to deprivation in future studies.

We examined the data regarding the use of “clearance” and “sampling” closely and found that in only one out of five Glasgow hospitals was the term “sampling” used to any significant extent. This led us to conclude that there was no evidence to suggest that the use of these terms or the procedure was influenced by the socioeconomic status of the patient. Pathology records in that particular hospital were also incomplete and did not always document the number of nodes.

Robinson's reference to the national standard of two weeks' waiting time again relates to current policy rather than practice at the time when participants in our study were managed. During 1992 and 1993 one Glasgow hospital had two new patient clinics each week while the other four had one. The hospital with two clinics serves an area in which there are several affluent post codes. That is why we argue that evidence for differences in the management of women from affluent and deprived areas resulting from by our data can all be explained by differences in hospital policy.

Williams and Fielder highlight the importance of data on patient delay before presentation. For our study we were not able to obtain these data but included delays occurring after the first presentation to the general practitioner. The size and stage of the early cancer group have been described elsewhere. No difference in pathological criteria was found between the women living in affluent and deprived areas.<sup>1</sup> Screened cases are included in this study, but analysis of these cases did not alter the final conclusions.

We agree with Oliver on the importance of new strategies being developed to address these inequalities. Our view is that better outcomes from breast cancer in women living in deprived areas are most likely to come from better understanding of the role of comorbidity and related host and environmental factors.

## References

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