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NCI Accused Of Forsaking Its Mission In House Hearings On Screening Statement

NCI Director Samuel Broder had two bad days on Capitol Hill last week.

Called to the Hill to explain the NCI withdrawal from the 1987 consensus guidelines for screening mammography, Broder sat glum as witnesses and House members accused the Institute of racism, sexism, forsaking its mission as a public health institution, lack of cooperation with a congressional investigation and rolling back the clock on women's health.

House members appeared to be taking turns attacking Broder and NCI: Patricia Schroeder (D-CO) called the Institute an "all-boys club," Bernard Sanders (I-VT) called for pinpointing the racists

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In Brief

Cancer Prevention Fellowship Program Applicants Sought; Grant Funds Available

NCI's CANCER PREVENTION Fellowship Program is accepting applications from MDs, other clinicians, and PhDs, to train in the field of cancer prevention and control. The program offers Master of Public Health training the first year at accredited universities, followed by independent research within the Div. of Cancer Prevention & Control. Applications for the program are available from Douglas Weed, DCPC, NCI, Executive Plaza South T-41, Bethesda, MD 20892, Tel. 301/496-8640, FAX 301/402-4863. The program also offers a Summer Cancer Prevention and Control Academic Course open to staff from cancer centers, universities, health departments, and industry interested in learning the principles and practices of cancer prevention and control. . . . **INVESTIGATOR AWARDS** in health policy research are being offered by the Robert Wood Johnson Foundation. The four-year program will provide $8 million to fund grants ranging from $100,000 to $250,000 for one to three years. Contact: Robin Osborn, deputy director, Foundation for Health Services Research, 1350 Connecticut Ave. NW Suite 1100, Washington, DC 20036, Tel. 202/223-2477. April 15 is the letter of intent receipt date. . . . **PRESIDENT'S CANCER PANEL** is scheduled to meet April 7-8, Bethesda Holiday Inn, Bethesda, MD. Topic of discussion is "Avoidable Causes of Cancer." The meeting is open to the public.

10-Page Issue

Broder Grilled On Capitol Hill Over Mammography Statement

(Continued from page 1)

and sexists and jettisoning them from government service and Edolphus Towns (D-NY) lectured Broder on what he characterized as the mission of NCI:

"Like it or not, you are the National Cancer Institute," said Towns, chairman of the Subcommittee on Human Resources and Intergovernmental Relations of the Committee on Government Operations. "Women are looking to you to tell them whether they should or should not have mammograms. You are the ones that set the tone."

That was only Day One, the March 8 hearing of Towns' subcommittee, which is investigating the Institute's change of mind on the guidelines.

On Day Two, at the March 9 hearing of the Subcommittee on Aging of the Senate Committee on Labor and Human Services, Broder found himself under questioning by Sen. Barbara Boxer (D-CA), who vowed that she would not sit still as the Administration is abandoning mammography as a screening measure for younger women.

Through the two days of hearings, Broder reiterated that NCI, being a research institution, needs either a scientific consensus or clinical data to continue adherence to the old guidelines. Having neither, the Institute had to reconsider the guidelines.

"The process had been launched before President Clinton was elected," Broder said at the Towns hearing. "This was not done as part of an expedience for health care reform. There is no one who could force me to do something on that basis."

Whether it was science that shaped policy or policy that shaped science, the NCI position on mammography, reflected in the President's Health Security Act, pit Broder and the Administration against women's health and cancer patient advocates.

While NCI reiterates that scientists disagree on the value of screening mammography for women between 40 and 50, many on Caption Hill appear to be asking a different question: should the health care plan err on the side of saving money, or should it err on the side of saving lives while waiting for scientists to settle their arguments?

Endorsing Clinton Plan—Indirectly

Over two days of hearings, Broder repeatedly stated that NCI is a science-driven agency not involved in policymaking. At one point, asked by Boxer whether the benefits package under the Health Security Act would reimburse baseline mammograms for 40-year-old women, Broder deflected the question to Philip Lee, HHS assistant secretary for Health.

"I have no standing to comment on that," Broder said.

However, as he addressed the issue of health care reform, Broder gave an endorsement to the President's plan for its provision of universal coverage.

"We at the NIH can develop new knowledge that in a paradoxical way can generate inequities in the larger society," Broder said.

"If we do no have universal coverage, as lifesaving interventions are developed and at the same time, if certain underserved groups do not have access to the new knowledge that we are generating, their health statistics may actually get worse compared to other groups that do have such access," Broder said at the Senate hearing chaired by Barbara Mikulski (D-MD). "What is the use of us generating a new intervention or a new form of adjuvant therapy for breast cancer if only some individuals have access to it?"

Broder said the patient and her physician should discuss all the potential benefits as well as potential pitfalls of screening mammography, which include the possibility of false-negative and false-positive results, unnecessary follow-up biopsies, as well as the potential risk of exposure to ionizing radiation. Only after that, the woman and her physician would be able to make a determination.

"We want to empower women," Broder said.

"But we are women who are empowered," Boxer retorted. "And we are saying to you, we want to make sure that we are getting unequivocal science before

THE CANCER LETTER

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we throw out the tools that we fought so hard to get... We are going to take your advisory information, and we are going to act in the best interest of women and the men in this country, who need us around."

Towns Investigation

To a great extent, the Towns investigation of NCI's decision to withdraw from the consensus on guidelines for screening mammography is centered around a dispute over the Institute's mandate.

"Dr. Broder, as chairman of this subcommittee, let me tell you today that I do not believe that science alone, to the exclusion of all other evidence on cancer detection, is the mission of the NCI," Towns said.

"If it were, I do not understand why Congress needs to allocate $2.1 billion —that's B as in boy— to NCI's hunger to conduct pure science.

"Your mission is to prevent, detect and cure cancer, using all available evidence. That's the information that I have. Your scientific subjects are not laboratory rats, but thousands of American women. NCI does not exist in a vacuum. Your revised guidelines are not an experiment in any isolated lab out in Bethesda.

"This is the real world. We are talking about life. And we are talking about death, Dr. Broder," he said.

Towns said minority women were insufficiently represented in the eight clinical trials that NCI used in the meta-analysis, which led the Institute to conclude that screening mammography does not save the lives of younger women.

"Only one trial was conducted on American women, and that was the oldest trial in the group, with the oldest technology," Towns said. "I fail to understand how NCI can make this unprecedented move based on a science that evaluated Swedish, Canadian and English population groups, which are lacking the ethnic and minority makeup of the American women."

Towns, who had requested over 500 documents from NCI, said the Institute did not provide two documents: minutes from a meeting of the NCI Executive Committee and a memorandum from an NCI staff member who was opposed to the change of guidelines.

"Let me say this to you, Dr. Broder, so we understand each other: I don't plan to go away," Towns said.

Testifying before the Towns subcommittee, Schroeder, co-chair of the Congressional Caucus for Women's issues said the change of guidelines "fits in with how the federal government has been treating women's health all across the board."

"We are still working to get more women into NCI, and into all the National Institutes of Health, and into the scientific world," Schroeder said. "It's been a great all-boys club. It really has been a cultural thing."

"Cultural-shmultural!" retorted Sanders. "If they can't catch on with what's going on in the 20th century, they really should not be working for the U.S. government. And we should look at that."

At the two days of hearings only one member of Congress, Rep. John Mica (R-FL) came to NCI's defense, albeit not specifically on the subject of mammography screening. "We are directing science all over the ball park, and we are not accomplishing the basic research mission," Mica said to Schroeder.

Yesterday's Technology?

Broder acknowledged that minority women were underrepresented in the European and Canadian studies that were used in meta-analysis.

However, Broder said the U.S. data, from the Health Insurance Plan (HIP) trial, included 17 percent African-American women. Addressing Towns' accusation of withholding materials, Broder said the Institute's failure to produce documents was unintentional. The materials were provided the day before the hearing, after he asked for them specifically, Towns said.

"There are no secret meetings," Broder said. "All of the facts that went into this decision, awesome as it is, were based on information which is in the public record. There is no confidential information that is being withheld. When there is opposition, we do not attempt to suppress it. In fact, we highlight opposition."

Throughout the two hearings Broder characterized mammography as a technology that has nearly reached its limit in the detection of breast cancer. Moreover, Broder said the procedure could harm some women.

"There may be certain genes that predispose that a woman should avoid ionizing radiation," Broder said at the Towns hearing.

According to Broder, the problems with the procedure include:

—**The potential of a high false-negative rate in younger women.** It is possible that mammography has an inherent false-negative rate in younger women, Broder said. "Some women have a microscopic spread

at an early stage," Broder said at Mikulski's hearing. "That microscopic spread in younger women might—might—occur at a very early stage. So the issue is not necessarily whether mammography picks up the tumor, but what treatment occurs afterwards."

—The promise of newer detection modalities. In his statement submitted for the record at Towns hearing, Broder wrote, "Even though we do believe we are already fully exploiting the strengths of mammography, we do believe that some new technologies, such as digital mammography and magnetic resonance imaging will improve imaging capabilities... And we continue to work toward simple screening tests, possibly blood tests, that would pick up molecular evidence of breast cancer or breast cancer susceptibility, and at the same time, might be the basis of new and effective therapies."

—Difficulties of conducting randomized clinical trials in the U.S. to find out whether mammography is an effective detection technology for younger women. "One question is, can you even do a randomized clinical trial?" Broder said at the Towns hearing. "This is an important issue. We will look into it. But many women will object to having a computer essentially tell them they will either get mammography or not and that they have a moral obligation to adhere to what the computer has said."

Once Again: 'What Would You Recommend, Dr. Broder?'

The following are excerpted highlights of testimony by NCI Director Samuel Broder at the March 8 hearing of the Subcommittee on Human Resources and Intergovernmental Relations of the House Committee on Government Operations and the March 9 hearing of the Subcommittee on Aging of the Senate Committee on Labor and Human Resources.

Rep. Edolphus Towns (D-NY): I have here a quote from the Sept. 24, 1993, **Cancer Letter.** Did you in fact make this statement: "What I would do as an individual is recommend an annual mammogram. But I can't recommend it to the public because I don't have the facts."

Dr. Broder, explain to me how you can reconcile holding your own patients to a higher standard than the rest of American women. Are you saying what's good for American women is not good enough for your patients?

BRODER: That statement has been widely misunderstood. The point I wanted to make with that statement—thank you for the opportunity to clarify that—is that we can't make policy, from the standpoint of a government agency, to tell doctors throughout the country and individual women throughout the country what to do as though we are acting as individual doctors.

No one should tell women they are going to get mammography because it's proven that it's going to save their lives. I think mammography for women between ages 40 and 50 has been automated.

And I don't necessarily object to that one way or the other. What I am asking is that mammography be accomplished within the practice of medicine, that it expand the standard of medicine, not replace it. The individual doctor has to know the individual patient. He has to know things about her. And the individual patient has to know the doctor.

■ ■ ■

Sen. Barbara Boxer (D-CA): Am I incorrect when I ask you this, is it not so that breast cancer is the leading cause of death for women between the age of 40 and 49?

BRODER: It certainly is.

BOXER: In the President's plan, do we call for a baseline at age 40? Is that included?

BRODER: I have no standing to comment on that.

Philip Lee [HHS Assistant Secretary for Health]: As I understand it, we do not have a baseline at age 40. We begin at age 50.

BOXER: Correct me if I am wrong, whoever is the expert, I understand that 46,000 women die every year from breast cancer.

BRODER: That is absolutely correct.

BOXER: And that 80 percent of breast cancer occurs in women over the age of 50. Is that correct?

BRODER: That's correct.

BOXER: Every single year we will have about 36,400 women in their forties who will be diagnosed with breast cancer. What are the best tools we have at our disposal to fight breast cancer? Can you name those, Dr. Broder?

BRODER: I believe that this should be taken from the context of the total picture first. And then I will respond to the specifics of your question. What we need to do, at least at the NCI's level, is to provide the facts as best as we know them.

BOXER: Okay... What are the best tools we have to detect breast cancer?

BRODER: On the basis of clinical trials and on

the basis of a scientific consensus, for women over the age of 50 the best early detection tool we have is mammography coupled with a clinical breast exam. I believe those must be linked together. Although some in the community have separated them. Clinical trials data do not permit division between those two.

BOXER: When a woman is 48, that's not true?

BRODER: What we can say is that on the basis of the available randomized clinical trials, between the ages of 40 and 50, screening mammography has not resulted in a reduction in death rate. There is extreme polarization and controversy in the scientific community. Many individuals of good will and of comparable intellect, have looked at the data and have come to opposing conclusions. We, as a scientific agency, cannot give a general statement that screening mammography will reduce the death rate in that population.

BOXER: What happens at age 50 that suddenly this becomes a good tool that at age 48, 49, or 47 it is not a good tool?

BRODER: You are asking a very important question. What I can say is that all parties agree that mammography has a better positive predictive value and is able to achieve a more dramatic success in women over 50. And the reason for this, in part, the breasts of younger women are radiographically dense. Some studies have suggested that false negative rates may be as high as 40 percent.

There are some women for whom the tumor is actually palpable, yet still not detectable on a screening mammography. It is possible that in some young women the disease metastasizes on a microscopic basis. Very few women die of a primary cancer. That is not what kills them. Some women have a microscopic spread at a very early stage. That microscopic spread might—might—in younger women occur at an extremely early stage. So the issue is not necessarily whether mammography picks up the tumor, but what treatment occurs afterwards.

The other factor that's frequently lost is that mammography is only a prelude to what has to happen. Mammography alone as a single thing has never saved anybody's life. It is what happens after mammography or detection by any other means. And so I think part of the discussion also has to focus on whether we giving adjuvant therapy.

BOXER: I don't think anybody has ever said that mammography stops cancer. It detects cancer. We all know that. But as you said, it is not completely clear, and as I understand it, there are 21 other national medical organizations that do not agree with this conclusion. Is that correct? Including the American Cancer Society.

BRODER: That may be even higher. But the American College of Physicians certainly agrees with our fact statement.

BOXER: I am not willing to throw out this diagnostic tool. Unless there is clear scientific evidence that it doesn't save lives. I don't think we have this scientific evidence yet.

BRODER: Let me briefly say, we want to empower women...

BOXER: But we are women who are empowered. [Laughter] And what we are saying to you is, we want to make sure that we are getting unequivocal science before we throw out the tools that we fought so hard to get. And when you have 46,000 women a year dying, we are empowered. We are going to take your advisory information, and we are going to act in the best interest of the women and the men in this country, who need us around.

Women's Caucus Seeks Wider Coverage Of Mammography

The Congressional Caucus for Women's Issues last week called for a broader coverage of screening mammography in any health care package that comes before Congress.

The caucus calls for reimbursement of mammography screening for women between 40 and 49 willing to make a copayment. Under the proposal, the procedure would be reimbursed entirely for women over 50. Moreover, an annual clinical breast exam would be covered for all women over 40.

"With all the conflicting recommendations that are coming from a number of highly respected sources, women need to know that screening mammograms will be covered," caucus co-chair, Rep. Patricia Schroeder (D-CO) said in a press release.

"Sending women the message that some mammograms may not be covered sends the message that mammograms are not important—and that's a dangerous message," Schroeder said.

The position adopted by the caucus was introduced as a resolution in the House. A similar resolution was introduced by Rep. Edolphus Towns (D-NY).

In congressional testimony last week, NCI Director Samuel Broder said the Institute planned to hold a workshop with the American Cancer Society

in an attempt to arrive at new consensus guidelines on mammography screening.

Meanwhile, sources in breast cancer advocacy groups said to **The Cancer Letter** that they were frustrated with the debate over mammography threatening to overshadow the broader issues, including the importance of the recommendations expected to be included in the strategic plan on breast cancer.

The plan, which is being drafted following a conference held by HHS Secretary Donna Shalala Dec. 14, 1993, is expected to be completed before April 1, HHS officials said.

NSABP Researcher Falsified Data, Federal Inquiry Finds

An NIH investigation has found that a Canadian researcher falsified data over a period of 15 years in order to enroll larger numbers of patients in NCI-funded clinical trials that changed the way breast cancer is treated.

The NIH Office of Research Integrity found that Roger Poisson, a professor of surgery at Univ. of Montreal, committed scientific misconduct consisting of fabricating or falsifying data on 99 patients enrolled in 14 clinical trials coordinated by the National Surgical Adjuvant Breast & Bowel Project.

NCI and NSABP officials, in statements released this week following a story in The Chicago Tribune, said the misconduct did not affect the outcome of the clinical trials. Among the studies to which Poisson accrued patients was the landmark NSABP trial which showed that women with early breast cancer have the same disease-free survival whether treated with mastectomy or breast-sparing lumpectomy.

Poisson, principal investigator on an NCI cooperative agreement with the Univ. of Montreal's St. Luc Hospital, enrolled 1,511 patients on 22 NSABP protocols over 15 years. The federal investigation involving NIH, NCI and the Food & Drug Administration documented 115 instances of data falsification or fabrication in 99 of the patients, or 7 percent of the St. Luc total accrual.

The misconduct involved falsification or fabrication of data necessary to meet the entry criteria for the studies, according to the ORI report on the investigation. The misconduct included changing the dates of surgeries performed prior to patients enrolling in studies, altering dates of biopsies, changing or fabricating estrogen receptor values, altering dates of chemotherapy, and lack of appropriate informed consent, ORI said.

Only a few of the falsifications could have resulted in inappropriate treatment, ORI said. In one case, a patient with a history of congestive heart failure was entered onto a protocol using the drug Adriamycin, which has cardiac toxicity.

No Change In Breast Study Findings

NCI and the Univ. of Pittsburgh, where NSABP headquarters is located, issued statements to reassure physicians and the public that the conclusions of the breast cancer research studies remain unchanged even after Poisson's data are removed. The 22 NSABP protocols in which Poisson participated enrolled more than 30,000 women in the U.S. and Canada.

The ORI findings were issued in February 1993, but Poisson's case was included with 13 other cases of misconduct in a short press release. Federal investigators expressed frustration that NSABP had not moved quickly to make public a reanalysis of the clinical trials and notify medical journals.

NSABP presented the reanalysis to ORI investigators in March 1992, according to Dorothy MacFarlane, ORI senior medical officer. "We knew early on that this would not change the major conclusions of the research," MacFarlane said to **The Cancer Letter**. "We did urge the NSABP and NCI to publish reanalyses of the studies in which St. Luc Hospital had entered large numbers of patients. We expected that would be when the [ORI] report was released last year, and that has not happened."

MacFarlane said NSABP waited eight months from the time the falsifications were suspected to inform NCI and NIH of the discrepancies. "NSABP should have called us immediately," she said.

NSABP Chairman Bernard Fisher said his group discovered Poisson's falsifications, investigated the researcher's data in a site visit, and brought it to the attention of federal officials.

"We don't think we did delay," Fisher said. "As soon as we documented it, we reported it."

The group is working as quickly as possible to review the massive amount of data involved in the NSABP studies, Fisher said. Two articles are being prepared for publication in peer reviewed journals and a separate, 50-page report is to be sent to NSABP participants in the next few months.

Some observers, however, accused the NSABP with attempting to cover up the misconduct of its researcher.

"I am furious that they kept this information from us for two years," said Fran Visco, president of the National Breast Cancer Coalition and member of the President's Cancer Panel. "How can we trust them? What other information are they keeping from us?

"We don't trust the data we are going to get from Dr. Fisher or NCI," Visco said to **The Cancer Letter**. "We are going to demand that someone else look at that data very carefully. Dr. Fisher knew about this for two years and NCI knew about it for two years and did not tell the public. It's patronizing."

Fisher said the NSABP took appropriate action throughout the investigation. "We were the ones who discovered the fraud. We were the ones who reported it," Fisher said. "The ORI investigation confirmed what we had reported, but that investigation took over a two-year period, at which time we were embargoed from speaking to anybody."

The Univ. of Pittsburgh research integrity office did not notify NSABP about the final ORI report until last April, Fisher said. Since that time, the group has been working on publication of the reanalysis.

"This involves huge amounts of data, printouts, and meticulous preparation, and figuring out how to take this mass of data and make this presentable, together with a commentary and the issues related to the reporting," Fisher said.

The NSABP reanalysis presented to ORI was reviewed and confirmed by NCI statisticians, according to the university. "Women involved in all NSABP studies and treated as a result of this research can be assured of the appropriateness of their therapy," the Pittsburgh statement said.

Motivation Was Not Financial

Poisson has been barred from receiving federal research funds for eight years, and NCI has begun a process to recover money it paid St. Luc Hospital for its participation in the studies, an estimated $1 million in grant funds.

Evelyn Jerassy, a lawyer for Poisson, said the researcher was surprised by the eight-year restriction. "At no time did Dr. Poisson benefit financially from this, and at no time did Dr. Poisson endanger the health of patients," Jerassy said to **The Cancer Letter**. "We feel the reliability of the studies were not affected. Once patients were entered on protocols, they received proper treatment and diagnosis."

The Chicago Tribune reported that one federal investigator described Poisson's motivation as an "ego trip" that gained the researcher co-authorship on several of Fisher's papers.

That was not the case, said Jerassy, of the Montreal law firm Phillips & Vineberg. "If you know Dr. Poisson, you know that is not his motivation," Jerassy said. "His primary concern was to see as many patients as possible enter on the protocols because they would receive better treatment, he thought, than not being on the study."

Discrepancies in the medical records for Poisson's patients first came to light in June 1990 when NSABP data managers found two reports of a breast cancer operation for a St. Luc patient, according to the ORI report.

The records were identical, except for different dates of surgery, one of which would have made the patient eligible for the study and the other which would have made the patient ineligible, the ORI said.

Three months later, NSABP conducted a site visit and audited a larger sample of charts than is usual. In 13 of 20 cases, informed consent documents were signed after the date patients were randomized, contrary to federal requirements.

Fisher suspended the accrual of new patients from St. Luc Hospital to NSABP studies in February 1991, and ORI began its investigation later that month. NSABP, ORI, and NCI staff audited the records of all 1,511 patients in four visits to the hospital in 1991.

ORI consulted two outside experts in the review: Larry Norton, chief of breast and gynecologic cancer medicine, Memorial Sloan-Kettering Cancer Center; and William Wood, chairman of the surgery department, Emory Univ. School of Medicine.

According to the ORI report, the experts said the falsification had varied from issues of minor importance to the research to "total fabrication." The medical issues also varied from "trivial" to "serious," such as the patient with history of heart failure entered onto an Adriamycin protocol, and disguising the fact that another patient had a bilateral breast cancer.

"Once the patient was on study, however, the treatment and follow-up generally appear to have been carried out according to the protocols," the ORI report said.

According to the report, Poisson "claimed full responsibility for the data falsification and fabrication." Poisson's data management staff knew about the misconduct and admitted to making the fabrications at Poisson's request, ORI said. In some of the cases, the data managers left notes in the research files to indicate which were the true data.

"The findings are serious in that in most cases

fabricated or falsified data misrepresented the study subjects as meeting the study criteria, when, in fact, they did not, or the information to determine whether they met the criteria was not available because the necessary tests had not been performed," the ORI report said. "The findings were also serious in light of the importance of NSABP study results in modifying standard medical practices for patients with breast and bowel cancers."

Discrepancies In Tamoxifen Trials

According to the ORI report, the 1,511 St. Luc patients represented less than 1 percent of the total NSABP accrual in five out of 22 studies, 1 to 4 percent in 10 of the studies, and 4 to nearly 8 percent in four of the studies. In three studies, the St. Luc accrual was more significant:

—In study B-06, a protocol to compare segmental mastectomy and axillary dissection with and without radiation of the breast and total mastectomy and axillary dissection, 16 percent of the total accrual, or 354 patients, were from St. Luc Hospital.

—In study B-13, a clinical trial to assess sequential MTX then 5-FU in patients with primary breast cancer and negative axillary nodes whose tumors are negative for estrogen receptors, 13.6 percent, or 103 patients, were from St. Luc.

—In study B-18, a "unified" trial to compare short intensive preoperative systemic Adriamycin plus cyclophosphamide therapy with similar therapy administered in conventional postoperative fashion, 16.5 percent, or 210 patients, were from St. Luc.

Public attention this week focused on the lumpectomy study, but the majority of the discrepancies ORI documented occurred in three key NSABP studies comparing tamoxifen to other therapies for treatment of breast cancer.

Of the 99 patients whose cases involved discrepancies, 35 occurred in study B-14, a trial to assess tamoxifen in patients with node negative, estrogen receptor positive breast cancer. There were 12 cases in study B-15, a three-arm trial comparing tamoxifen alone with two other regimens for node positive breast cancer. There were 17 cases in study B-16, another three-arm trial comparing tamoxifen alone with two other regimens in node positive patients 60-70 years old.

"I was committed to helping the NSABP obtain the answers rapidly and finishing protocols within a couple of years," Poisson wrote in a letter to investigators, a copy of which was included in the ORI report. "I have always found it very distressing to see so many surgeons not willing to register their patients into good studies... In retrospect, one of my greatest errors was in not having an experienced and rigid case manager, checking thoroughly the minor details of the eligibility criteria, even the ones which appeared to me to be minor."

Regarding the changing of dates in order to enroll patients, Poisson wrote in another letter, "It has more to do with the fact that I always feel sorry for a nice case to be denied the right to enter a good protocol just on account of trivial details: a difference of a few days in the date of surgery because the patient took a long time to decide."

Poisson called the falsifications "stupid mistakes." For one trial, he wrote, he tried to push for expanding the "window" between surgery and entry onto protocol from 28 to 56 days. Later, the protocol was modified.

"I did not recognize enough gravity in changing things or not reporting things which I thought were not significant," Poisson wrote. "I never intended to harm the NSABP.... The discrepancies or changes...occurred mainly for reasons of expediency."

NCI: The Only Serious Instance of Misconduct

The Poisson case is rare considering the large number of investigators and patients involved in NCI-supported clinical trials, an Institute official said.

"This is the only major instance of misconduct that we have uncovered in our site visiting process in the past 10 years," said Bruce Chabner, director of NCI's Div. of Cancer Treatment.

NCI has commissioned a third, independent analysis of the data to assure the validity of the NSABP lumpectomy study results, the Institute said in a statement. At least five other large, independent clinical trials confirmed the results of the NSABP lumpectomy study, NCI said.

"No change is recommended in breast cancer treatment options available to American women," the NCI statement said. "The current knowledge about the comparability of mastectomy versus lumpectomy plus radiation rests on a solid foundation of work from many investigators and the single reports of one investigator at one institution do not alter any of the conclusions of how to treat breast cancer."

The American Assn. for Cancer Research and the American Society of Clinical Oncology agreed to give Fisher a chance to present the reanalysis at the annual meetings of the two organizations, sources said.

Files Of Hilton Head, SC, Doctor Subpoenaed By FBI

The Federal Bureau of Investigations has subpoenaed hospital documents related to Rajko Medenica, a controversial physician who practices in Hilton Head, SC, and Denver, sources said to **The Cancer Letter**.

Medenica claims outstanding successes in the treatment of cancer.

The Hilton Head Island Packet, the local newspaper, reported earlier this month that Hilton Head Hospital was served a subpoena requesting hospital records. Sources confirmed to **The Cancer Letter** that the subpoena had been served and that the documents requested concerned information related to Medenica.

"We cannot confirm or deny that any investigation is going on," a spokesman for the US Attorney's Office in Columbia, SC, said to **The Cancer Letter**.

In another development, St. Anthony Hospital in the Denver area has downgraded Medenica's recently granted full privileges, sources said.

Sources who spoke on condition of not being identified said to **The Cancer Letter** that Medenica was granted full privileges at the hospital earlier this year, but those privileges were partially suspended late last month.

Medenica is appealing that action, sources said.

In another development, court documents filed in South Carolina last week allege that last spring Hilton Head Hospital and Medenica attempted to make an agreement which would have allowed the physician to move his practice to Colorado.

The motion quotes a transcript of a telephone conversation in which a man identified in the papers as Steven Caywood, at that time the administrator of Hilton Head Hospital, described a proposed deal to induce Medenica to leave the hospital. The conversation took place last March, court papers said.

"The key issues here are how to handle this in a way that basically would allow Medenica to relocate in a way that we don't end up facing F. Lee Bailey [attorney who has represented Medenica in a number of disputes] and hung up in a long, drawn out procedure," the man is quoted saying. "We want to make sure that [Medenica] gets secured in Denver at the hospital where he is going. They want him. They know what they are getting...

"I have talked at length with the attorneys... about the implications on the National Practitioner Data Bank... And if Rajko self-initiates the move... then everything is clean.

"We are going to be clean, because any inquiries that we get about him in the future, our response is going to be a very succinct procedure as to the arrangement with Rajko: He was on the staff..., this is what he did. End of sentence.

"If they call or write and want more information, or particularly peer review information, we will be responding back and writing them, saying 'We cannot release that without Dr. Medenica's written approval.' And if he gives permission, then we will obviously release what we have."

The National Practitioner Data Bank keeps account of complaints, sanctions and actions against physicians. The data bank is open to government agencies and hospital administrators.

According to the motion, the conversation was taped by Jane Gehlsen, an oncologist who practiced on Hilton Head and who had questioned Medenica's credentials.

The transcript of the conversation was contained in a motion for a summary judgment in a suit filed last fall by Medenica's patients against three Hilton Head physicians, including Gehlsen. The patients claimed that the physicians used the peer review process as a means to drive Medenica off the island.

In the motion filed March 7 at the US District Court in Beaufort, SC, the defendants described the suit by Medenica's patients as "an effort to intimidate all doctors on the Hilton Head Hospital Executive Committee from further peer review of Dr. Medenica." The physicians seek a summary judgment and reimbursement for their legal fees and other expenses.

Contacted by **The Cancer Letter**, Caywood, who has since resigned from the hospital, confirmed the authenticity of the tape. "I did not know that Dr. Gehlsen was taping me at that time," he said. "I think it's very unprofessional."

"I know nothing of this motion, because I was not involved," John Horty, special counsel to the hospital, said to **The Cancer Letter**. "The hospital was not a party to this suit. As far as any agreement with respect to the National Practitioner Data Bank, there was none." Horty serves on the advisory committee to the National Practitioner Data Bank.

A telephone call to F. Lee Bailey was not returned.

Charles Stevinson, a plaintiff in the suit against the three physicians, said he knew of no deal aimed at moving Medenica's practice from Hilton Head. "If

such a deal were made inside the Hilton Head Hospital, I don't know anything about it," Stevinson said to **The Cancer Letter**.

"I would have had to be aware of it, because I would have had to prepare the space for his laboratories and his expanded practice in Denver," Stevinson said.

Medenica's full privileges at Hilton Head Hospital were scheduled for renewal in April, 1993. However, Medenica was granted a series of extensions while the hospital was designing a peer review mechanism appropriate for his practice (**The Cancer Letter,** April 30 and June 4, 1993). In an agreement last October, Medenica consented to limiting his treatments to standard oncology protocols as well as to peer review by an outside physician who would be responsible to the hospital's institutional review board (**The Cancer Letter**, Nov. 26, 1993).

Letter to the Editor

The Only Efficacious Role For Mammography: Screening

To the Editor:

Dr. Wishart, in his letter to **The Cancer Letter** (Feb. 25) suggests that "academic physicians" are being "paternalistic" when we suggest that the issues surrounding breast cancer screening are complex. I fully agree that women and physicians should be provided with all the information so that they can make informed decisions, but the fact is that these are complicated issues and not a matter of "simple statistics." NCI has certainly not provided complete information. The basic value of mammography is misunderstood.

The distinction is frequently made, most recently by Dr. Broder and Dr. Wishart, between "screening mammography" and "diagnostic mammography" as if there is some dramatic difference. This is nonsense. Mammography is rarely "diagnostic." It can rarely be used to determine the histology of an abnormality, and should rarely be relied on for altering the management of a clinically evident problem.

Dr. Broder feels mammography is only indicated in women under 50 as a "diagnostic" procedure. This premise can be examined. Assume that a woman, age 45, feels a lump in her breast. Her doctor feels it and the clinical examination produces a certain level of concern. The woman then has a mammogram. There are several possible results from the mammogram:

1. The lump is visible on the mammogram and has characteristics of a classically benign lesion such as a lipoma, or calcified fibroadenoma. This is one of the few situations where the mammogram <u>is</u> diagnostic and may alter patient care, but it is also extremely rare.

2. The lump is not visible on the mammogram. It is well established that there are cancers that are evident on clinical breast examination that are not visible on the mammogram, so the clinician cannot rely on a negative mammogram to exclude a cancer. The clinician must still pursue a diagnosis, and management is not altered. This is a fairly common situation.

3. The lump is visible on the mammogram, but its appearance is not specific. The clinician must still pursue the diagnosis, and management is not altered. This is also fairly common.

4. The lump is visible on the mammogram, and its morphologic characteristics are very suspicious for malignancy. This is fairly common when the lesion felt on clinical examination is actually cancer. It is possible that, without the additional mammographic evidence, the clinician might have decided that his/her clinical suspicion was not sufficiently high to pursue the diagnosis. If this is the case, then the mammogram caused earlier intervention and was valuable in clinical management. This scenario has never been documented scientifically, and is likely quite uncommon. Most palpable cancers that have characteristic appearances on mammography are also very suspicious on clinical examination, and the clinician would have pursued the diagnosis regardless of the mammogram results, and management is not altered.

Since the mammogram is rarely useful in altering the management of a clinically evident abnormality then the question remains: What is the value of "diagnostic mammography"?

The answer is: To search the remainder of the breast in question, and the contralateral breast for breast cancer that is not palpable. The major role for mammography in a woman who has a palpable abnormality is <u>screening</u>. The only efficacious role for mammography is <u>screening</u> to detect breast cancers before they become palpable. It is nonsense to suggest that mammography is valuable for the woman who has a lump, but not for screening.

I have no problem with Dr. Wishart's suggestion for "informed consent" for mammography as long as he agrees to obtain it before he performs a clinical breast examination. Clinical breast examination has never been shown in a randomized, controlled trial to lower the mortality from breast cancer among women ages 40-49. I hope he informs his patients that his clinical examination is more likely to lead to discovery of a suspicious lesion than mammography. I hope he also informs his patients that more biopsies are performed for benign lesions on the basis of CBE than on the basis of mammography. Finally, I hope he will inform his patients that if his fingers do find a cancer it is more likely to be at a larger size and later stage than if the lesion had been found by mammography.

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