tion of a similar programme is planned in Australia, and in the UK two labour MPs, B. Hiddon and P. Flynn, have asked Tony Blair to change the outdated law concerning drug addiction. There is doubt, however, that he will be inclined to do so since, as with the general law-and-order policy, he tends to favor the US solution of appointing a ‘drugs czar’ to lead and coordinate a policy so repressive that it doesn’t even allow the use of methadone. The fact that Blair is seeking an alliance with the Liberal Party, however, could help those, like the National Addiction Center (one of the best-known specialized institutes in the world), who are looking for a policy by which problems can be solved and not created.

Death rates in Russia rise dramatically: Worse than under Stalin

Russia has seen an enormous increase in death rates since the collapse of the Soviet Union in 1991.

Between 1984 and 1987 life expectancy at birth rose from 61.7 to 64.9 years in males and from 73.0 to 74.3 years in females, but in the 1987–1994 period it declined sharply – by 7.3 years for males and 3.3 years for females (Lancet 1997; 350: 383). An editorial accompanying the Lancet article argues that these wide discrepancies in life expectancy cannot be due to artefacts because age-specific mortality rates for neoplasms remained unchanged during this period (Lancet 1997; 350: 379). This almost incredible decline has also been dealt with many times (although the data were still only partial) also in the lay press; based on different calculations, it has been determined that in the territory of the former Soviet Union there are currently 500,000–1,000,000 more deaths annually than before 1991.

Some commentators even claim that “It is worse than during Stalin’s time”, and the authors of the Lancet paper state with regard to this appalling data that “The magnitude and steepness of the fluctuations in mortality rates and life expectancy reported here for Russia are without parallel in the modern era.” The steepest rise was seen for deaths related to alcohol and to accident or violence, but significant rates were also seen for deaths from infections, circulatory diseases, and respiratory problems. It is probable that the sudden deterioration in social conditions and therefore also of overall nutrition in combination with a sharp increase in the use of alcohol has been one of the main reasons for this almost unbelievable trend.

There can be no doubt that these data are closely related to the social turmoil resulting from the abrupt replacement of a state-guided society by an extreme free-market economy. That the situation will soon improve remains far from assured. For the present, at any rate, there are no signs of improvement at either the economic, social or political levels.

To what extent are cancer clinical trials imperilled in the UK?

While the new British government is increasing its support for the antismoking campaign and the use of mammography in screening programmes, it is far from certain that it will do the same for cancer clinical trials. The problem stems mainly from the ‘internal market’, a legacy of Mrs Thatcher.

Those rules distinguish sharply between the providers and the ‘purchasers’ (the state, other doctors, companies, etc.) of health care, and therefore, no one feels responsible for the financial burden of clinical trials; the large randomized and/or multicentric studies are the ones in most serious jeopardy (Nature Medicine, July 1997). During the electoral campaign the new Labour Party was vague about how it planned to reform the ‘internal market’ (Ann Oncol 1997; 8 (2): 102–3). New Health Minister Frank Dobson has promised that “new guidelines for clinical research” will be established to determine who will be in charge of securing their financial support, but in view of the strictures of the ‘internal market’, oncologists are sceptical that the government will be left enough leeway to regulate and therefore finance trials. In fact, Mr. Dobson also added, that problems with cancer trials will persist “unless new resources are found”...

The situation is not very different from the one prevailing in the US where the increasing power of ‘managed care’ has led to increased difficulties for clinical research, including cancer research. This topic will be discussed in greater detail in an upcoming issue of the Journal.
Will Jospin solve Villejuif’s problems?

The Institut Gustave-Roussy in Villejuif is the largest cancer center in Europe, with 550 beds and 2,700 employees (Ann Oncol 1995; 6 (1): 3-4). However, it has been plagued by strikes over the past two to three years; ever since the France government decreed a drastic reduction in the number of its hospital beds, on the basis of the general tendency to favour out-patient treatments, and the belief that too many beds have been allocated in France for acutely ill cancer patients.

The decision was found unacceptable, especially by the trade unions, which were striving to maintain the level of employment for nurses. The situation was particularly rough in 1996, but on and off during 1997 there were also strikes in protest against various proposals. The situation could improve under the new French government, led by Socialist Jospin. During the electoral campaign he promised to cut unemployment by reducing work time to an average of 35 hours a week, although some observers regarded this as mere electoral propaganda. However, at the end of August (Le Monde, 26-8-1997) the government announced completion of its plan to reduce to 35 hours, within two to three years, the average number of work hours in France. This is part of the so-called ‘Aubry plan’ (Martine Aubry, the daughter of the former president of the European Commission, Jacques Delors, is widely regarded as the politician with the most promising future in France), which calls for 350-400,000 new jobs within a year, mainly in the social and non-profit sector. It could be that many of the jobs at Villejuif will be saved by this plan, and that peace will return to the largest cancer center in Europe.

Eugenics: Did Hitler merely emulate others?

The forced sterilization of the mentally and physically handicapped has always been regarded as one of the more heinous of the crimes committed by the Nazi regime.

However, as discussed before in this journal with respect to the US (Ann Oncol 1995; 6 (5): 420), sociologists (though not the general public) have long known that similar inhumane laws were in effect before Hitler ascended to power. Laws similar to the American ones were also in effect around 1925–1930 in certain Swiss cantons, most notably Vaud. In fact, there were movements ‘to improve the human race’ (the pseudo-science ‘eugenics’) in many nations during the early decades of this century.

Only very recently, however, has it become known that roughly 100,000 women were involuntarily sterilized in the Scandinavian countries already in the 1920s. Most of them were mentally ill, but the law allowed this procedure to be applied also to the ‘socially unfit’.

The scandal was prompted by a report published in the daily Dagens Nyheter. Margot Wallström, Minister for Social Affairs, has decided to create an investigating committee, which should verify the extent of the facts. Although supposedly never applied after World War II (due to revulsion toward Nazi policy), at least in some Scandinavian countries the law remained on the books until about 1970. Some people have linked the philosophy which is behind these eugenic measures with the aggressive policy against drug abusers still in effect, especially in Sweden. In this context, however, Scandinavia today is less homogeneous than in the past. Just a few weeks ago Denmark decided to launch a programme for drug abusers similar to the one which is in successful operation in Switzerland (see this issue).
Awards, appointments

The Research Award and the Incentive Award of the Helmut Horten Foundation will be presented for the fourth time in Lugano on 14 November 1997. The Research Award of a total of one million Swiss francs will be shared by British child psychiatrist Prof. Sir Michael Llewellyn Rutter, Professor at the University of London, for his epidemiological studies in the field of child psychiatry, and American Prof. Alfred Sommer, Dean of the School of Hygiene and Health at The Johns Hopkins University in Baltimore. Dr. Sommer will be honored for his studies of the connection between vitamin A deficiency and infant mortality as well as its application in the Third World. The Incentive Award will go to Dr. Matthias Peter, a group leader at the Swiss Institute for Experimental Cancer Research (ISREC) in Epalinges sur Lausanne for his work in regulation of the cell cycle. The award includes a research grant amounting to 1,260,000 Swiss francs, to be spread over a period of three years, as well as a one-time sum of 50,000 Swiss francs to be used at the awardee's discretion.

Perhaps not everyone knows that...

...no evidence was found that a pregnancy after breast cancer treatment increases the probability of a poor outcome. These are the results of a retrospective evaluation of a series of 5,725 women with primary breast cancer, 45 years old or younger, of whom 173 subsequently became pregnant. The authors describe a non-significant reduction of the risk of death for women with full-term pregnancies (RR 0.55) as compared with those who had no full-term pregnancies (after adjustment for all known prognostic factors) [1].

...authors are more likely to publish randomized clinical trials in an English-language journal if the results were statistically significant. These are the results of a study on 40 pairs of reports in German and English. Only 35% of the German-language articles, compared with 62% of the English-language articles, reported significant (P < 0.05) differences in the main endpoint between study and control groups (P = 0.002). Overviews should thus take into account all published trials and not restrict their observation to those in the English-language literature [2].

...in animal models, pretreatment with G-CSF worsens intraocular inflammation through local production of tumor necrosis factor activated by the G-CSF. The authors describe a case of subretinal haemorrhage after the use of this agent in a four-year-old girl with neuroblastoma who had the complication which led to an irreversible loss of vision. Hematopoietic colony stimulating factors have been known to worsen autoimmune disorders [3].

...ectopic overexpression of cyclin D1 in breast cancer cells reverses the growth-inhibitory effects of antiestrogens in estrogen receptor-positive breast cancer cells, providing a potential mechanism for clinical antiestrogen resistance. Treatment with zinc was used in the experiment to induce the cyclin D1 overexpression [4].
...there is little evidence that living in homes characterized by high measured time weighted average magnetic-field levels or by the highest wire-code category increases the risk of acute lymphoblastic leukemia (ALL) in children. Previous studies found in fact an association between childhood leukemia and surrogate indicators of exposure to magnetic fields (power-line classification scheme known as 'wire coding'). These are the results of a study on 638 children with ALL and 620 controls [5].

...patients with breast cancer and without clinical suspicion of axillary node involvement should undergo routine sentinel-node biopsy, and may be spared complete axillary dissection when the sentinel node is disease-free. These are the conclusions of a study on 163 women with operable breast cancer. The results of the histological findings from the sentinel node were found to be accurate (predicting the nodal status) in 97.5% of the cases [6].

...cord blood is a feasible alternative source of hematopoietic stem cells for paediatric and some adult patients with major haematological disorders, particularly if the donor and the recipient are related. These are the results of a study on 143 transplantations of cord blood. Interesting is the observation that neutrophil recovery occurred in 94% of the patients who received 37 x 10 or more nucleated cells per kilogram from unrelated donors [7].

References


**Book review**


In an accompanying leaflet, this book is defined as a guide to physicians, nurses, pharmacists, and persons suffering from fatal diseases and their family and friends, as they struggle with the moral, religious and legal issues that accompany the idea of ending the life of the sufferer. The leaflet also states that the primary aim would be to allow those involved in this dilemma, either publicly or privately, to make the most informed decision. Notwithstanding the value of a book dealing with this difficult topic outside of strongly structured societies, associations or consumer groups, it seems to us that each individual situation comprises many more additional factors including discussions, personal experience, education, cultural attitudes, political views and religious beliefs.

The real main purpose of the book, as is more correctly stated in the introduction, is not to support or censure, but to elucidate; this is very useful because as physicians we must know how to respond to patients' requests and how to deal with them appropriately.

The book reflects the American attitude toward physician-assisted suicide, defined as a practice whose purpose is 'to help a patient in need avoid what he or she perceives as a far worse death, or avoid continued existence in a state he or she perceives to be worse than death'. Physician-assisted suicide has a much less negative connotation than euthanasia because of the active role of the patient and of the presumed lower chance of involuntary or non-voluntary death. The special session on the end-of-life management of cancer patients at the last ASCO meeting was quite informative in this regard, with the two speakers on the active ending of life dealing with physician-assisted suicide only – one of them in favour and the other strongly opposing it (also reporting incorrectly some figures of the Dutch survey on euthanasia) with the usual and unfounded argument that the issue could be simply overcome through the provision of adequate hospice care.

The chapter 'Euthanasia and euthanizing drugs in the Netherlands' by Gerrit Kimsa reports a more realistic and direct view of this practice, defined as 'the intentional termination of life by someone other than the patient at this patient's request'. The new terminology of medical decisions at the end of life, the so called MDELS, which includes four distinct areas: