and in the skin of the left arm. Therefore, in May 1997 she was given docetaxel as first line chemotherapy for metastatic breast cancer. A dose of 169 mg was administered over a one-hour infusion for two cycles every three weeks.

Both patients developed burning pain, hyperaemia, and appreciable epidermolysis between the fingers and the toes after two cycles of treatment. While the first patient continued docetaxel treatment, the second discontinued the therapy. After three cycles of docetaxel the first patient presented with multiple and bilateral onycholysis of the finger and toe nails with brown discoloration as a sign of bleeding beneath the nails. The second patient presented with so-called Beau-Reil lines, indicating that nail growth had stopped due to chemotherapy. Additionally, beginning onycholysis was observed at the basal layer of multiple finger and toe nails. In both patients a dermatological examination showed no evidence of infectious origin of the alterations.

To date, only a few case reports and letters have been published on the development of onycholysis associated with anthracyclines [1], mitozantrone [2] and etoposide [3]. After using docetaxel as first-line chemotherapy in the treatment of metastatic breast cancer, nail disorders, including ridging, pain, and onycholysis were reported to occur in 35% of the patients but rarely to be severe [4]. Recently, Slee reported a case of nail changes following seven courses of docetaxel at three-week intervals [5]. Although both of our patients had undergone previous treatment with anthracyclines and mitozantrone, the clinical course clearly showed that the nail changes were related to docetaxel. We therefore suggest that investigators should pay special attention to this uncommon side effect, in particular to the frequency of docetaxel-related onycholysis.

A. Obermair, M. Binder, M. Barrada, D. Bancher-Todesca, E. Asseryanis & E. Kubista
University Hospital Medical School Vienna, A-1090 Vienna, Austria

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Quality of life assessment in patients receiving adjuvant therapy for breast cancer: The IBCSG approach

Figure 1 of the recently published paper [1] is labeled incorrectly. The labeling of the lines is reversed. The information in the text, however, is correct: quality of life scores at time points when patients were assigned to receive CMF therapy were systematically lower compared to timepoints without assigned chemotherapy, although the difference diminished over time. We apologize for this error. The figure will be corrected on all reprints which are available by the undersigned. The corrected figure is printed herewith.

J. Bernhard
IBCSG Coordinating Center, 3008 Bern, Switzerland

Figure 1. Median PACIS scores in trial VII (postmenopausal node-positive patients) at time points where patients received chemotherapy. Groups are combined according to whether or not the patients were receiving chemotherapy at a given time point. All patients also received Tamoxifen. Higher scores indicate better adjustment. P-values are from ANOVA’s at each time point using 100 minus square root of PACIS, controlling for culture and excluding patients who recurred within the first 18.5 months. A, B, C, D refer to treatment groups (see text for description).

Reference