The war on cancer: time for a new terminology

The excellent *Lancet* Series on the cancer wars returned to the term cancer war as outlined by President Nixon in 1971. Cancer treatment with extensive surgery, radiation therapy from deep x-ray machines and toxic multiagent chemotherapy was all given in the hope and belief that more was better and that if we pushed hard enough we would cure more cancers.

Douglas Hanahan outlines a vision for correcting the missteps that our so-called war on cancer with "magic bullets" has caused.[1] However, he continues to use similar battlefield and warfare analogies. In developed countries, these analogies have contributed to over-diagnosis and over-treatment of some cancers, particularly prostate cancer. Despite all the very expensive and toxic radical "weapons" used, the mortality rate for prostate cancer in developed countries is still very similar or worse than in countries with much lower incidence.[2] This causes widespread distressing and unnecessary toxicities and suffering, or "collateral damage".

The misplaced battlefield analogy has led to 40 years of toxic and overly aggressive chemotherapy in incurable solid cancers for which no studies have shown that maximum tolerated doses of chemotherapy achieve longer survival or better quality of life than do minimum effective doses. This approach has led to inappropriate and toxic therapies for many patients with indolent diseases such as follicular low-grade non-Hodgkin lymphomas[3] and chronic lymphocytic leukaemia.[4] It has deprived many patients with advanced cancer from access to early palliative care referral for which there is strong evidence of benefit.[5] The war analogy has also set a poor example for appropriate use of high-quality evidence for realistic goal-setting and resource allocation.

Hasn't the time come to dispense with the battlefield analogies that have clearly failed us in so many ways, and adopt a new analogy of multidisciplinary treatment teams using collaboration to build lasting and sustaining treatment bridges?

I declare no competing interests.

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E-cigarette regulations in Italy: fluctuating and confusing

The regulation of electronic cigarette (e-cigarette) sales and use in public places largely varies by country and within countries.[1–3] In view of the scarcity of the evidence on e-cigarette's efficacy, safety, and ability to pollute indoor environment, any approach around e-cigarettes is likely to generate a debate.[1,3–5]

The Italian legislation on e-cigarette use in public places turned over three times within 6 months, during which time the evidence on the indoor pollution related to electronic smoking did not vary substantially. In June, 2013, e-cigarettes were banned from public places by a law decree. In September, 2013, a new law allowed e-cigarette smoking both indoors and outdoors, with the exclusion of schools. 3 months later, the Italian Parliament approved another e-cigarette ban, together with a 200% increase in taxation. Finally, because of controversies around norms included in the Government decree, unrelated to smoking, such regulation was then withdrawn by the government.

Fluctuating approaches are likely to create confusion in the population and among health-care professionals, and decrease the trust in and adherence to regulations. More caution is required by governments in issuing of policies on e-cigarette smoking, and, once a strategy is decided, this should be maintained until solid confuting evidence is available.[4] Certainly, further data are eagerly awaited.

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Time to reconsider thyroid cancer screening in Fukushima

In October, 2011, as part of the Fukushima Health Management Survey,[1] Fukushima prefecture implemented a thyroid ultrasound examination programme for all children younger than 18 years to "ensure early identification and treatment of thyroid cancer in children."[1] The Fukushima prefecture collected baseline thyroid cancer prevalence data until

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