

Debate on Cancer Policies

Editorial note: On February 4, 1992, at a press conference sponsored by a public interest group, Food and Water, Inc., a group of scientists, including Dr. Samuel S. Epstein, presented a statement at the National Press Club in Washington, D.C., criticizing the cancer policies of the National Cancer Institute (NCI), the American Cancer Society, and some 20 cancer centers. A few days earlier, a commentary on breast cancer by Dr. Epstein questioning the widespread use of mammography was published in the Los Angeles Times. We are pleased to present these statements in the Journal, along with a response from the NCI, a response from the American College of Radiology (ACR), and a rebuttal to these NCI and ACR responses from Dr. Epstein.

LOSING THE “WAR AGAINST CANCER”: A NEED FOR PUBLIC POLICY REFORMS*

Cancer now strikes one in three and kills one in four Americans, with over 500,000 deaths last year. Over the last decade, some 5 million Americans died of cancer and there is growing evidence that a substantial proportion of these deaths was avoidable.

We express grave concerns over the failure of the “war against cancer” since its inauguration by President Nixon and Congress on December 23, 1971. This failure is evidenced by the escalating incidence of cancer to epidemic proportions over recent decades. Paralleling and further compounding this failure is the absence of any significant improvement in the treatment and cure of the majority of all cancers. Notable exceptions are the successes with some relatively rare cancers, particularly those in children.

A recent report by the American Hospital Association predicts that cancer will become the leading cause of death by the year 2000 and the “dominant specialty” of American medicine. The costs in terms of suffering and death and the inflationary impact of cancer, now estimated at \$110 billion annually (nearly 2 percent of the GNP), is massive. These costs are major factors in the current health care crisis, with per-case Medicare payments exceeding those of any other disease.

We express further concerns that the generously funded cancer establishment, the National Cancer Institute (NCI), the American Cancer Society (ACS), and some twenty comprehensive cancer centers, have misled and confused the public and Congress by repeated claims that we are winning the war against cancer. In fact, the cancer establishment has continually minimized the evidence for increasing cancer rates, which it has largely attributed to smoking and dietary fat, while discontinuing or ignoring the causal role of avoidable exposures to industrial carcinogens in the air, food, water, and the workplace.

*The authors and signatories are listed at the end of this statement.

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Furthermore, the cancer establishment and major pharmaceutical companies have repeatedly made extravagant and unfounded claims for dramatic advances in the treatment and “cure” of cancer. Such claims are generally based on an initial reduction in tumor size (“tumor response”) rather than on prolongation of survival, let alone on the quality of life, which is often devastated by highly toxic treatments.

We propose the following reforms, not as a specific blueprint, but as general guidelines for redefining the mission and priorities of the NCI:

1. The NCI must give cancer cause and prevention at least equal emphasis, in terms of budgetary and personnel resources, as its other programs, including diagnosis, treatment, and basic research; NCI’s current annual budget is \$1.8 billion. This major shift in direction should be initiated immediately and completed within the next few years. This shift will also require careful monitoring and oversight to prevent misleading retention of old unrelated programs under new guises of cancer cause and prevention.

2. A high priority for the cancer prevention program should be a large-scale and ongoing national campaign to inform and educate the media and the public, besides Congress, the Administration, and the industry, that much cancer is avoidable and due to past exposures to chemical and physical carcinogens in air, water, food, and the workplace, as well as to lifestyle factors, particularly smoking. It should, however, be noted that a wide range of occupational exposures and urban air pollution have been incriminated as causes of lung cancer, besides smoking. Accordingly, the educational campaign should stress the critical importance of identifying and preventing the carcinogenic exposures and reducing them to the very lowest levels attainable within the earliest practically possible time.

3. The NCI should develop systematic programs for the qualitative and quantitative characterization of carcinogens in air, water, food, and the workplace, with particular emphasis on those that are avoidable. Such information should be made available to the general public, and particularly to subpopulations at high risk, by an explicit and ongoing “right to know” educational campaign, such as the specific labeling of food and consumer products with the identity and levels of all carcinogenic contaminants. While taking a lead in this program, the NCI should work cooperatively with federal and state regulatory health agencies and authorities, industry, public health and other professional societies, labor, and community-based citizen groups.

4. The NCI should cooperate with the National Institute of Environmental Health Sciences (NIEHS), and other NIH institutes, in investigating and publicizing other chronic toxic effects induced by carcinogens, including reproductive, neurological, hematological, and immunological diseases, besides cancer.

5. The NCI should cooperate with the National Institute for Occupational Safety and Health and other agencies to develop large-scale programs for monitoring, surveillance, and warning of occupational, ethnic, and other subpopulation groups at high risk of cancer due to known past exposures to chemical or physical carcinogens.

6. In close cooperation with key regulatory agencies and industry, the NCI should initiate large-scale research programs to develop noncarcinogenic products and processes as alternatives to those currently based on chemical and physical carcinogens. This program should also include research on the development of economic incentives for the reduction or phase-out of the use of industrial carcinogens, coupled with

economic disincentives for their continued use, especially when appropriate noncarcinogenic alternatives are available.

7. The NCI should provide scientific expertise to Congress, federal and state regulatory and health agencies and authorities, and industry on the fundamental scientific principles of carcinogenesis including: the validity of extrapolation to humans of data from valid animal carcinogenicity tests; the invalidity of using insensitive or otherwise questionable epidemiological data to negate the significance of valid animal carcinogenicity tests; and the scientific invalidity of efforts to set safe levels or thresholds for exposure to chemical and physical carcinogens. The NCI should stress that the key to cancer prevention is reducing or avoiding exposure to carcinogens, rather than accepting and attempting to “manage” such risk. Current administration policies are, however, based on questionable mathematical procedures of quantitative risk assessment applied to exposures to individual carcinogens, while concomitant exposures to other carcinogens in air, water, food, and the workplace are ignored or discounted.

8. The NCI should provide Congress and regulatory agencies with scientific expertise necessary to the development of legislation and regulation of carcinogens. Illustrative of such need is the Administration’s revocation in 1988 of the 1958 Delaney amendment to the Federal Food Drug and Cosmetic Act, banning the deliberate addition to foods of any level of carcinogen. This critical law was revoked in spite of the overwhelming endorsement of its scientific validity by a succession of expert committees over the past three decades. Neither the NCI, nor others in the cancer establishment, provided any scientific evidence challenging the validity of this revocation, including its likely impact on future cancer rates.

9. The limited programs on routine carcinogenicity testing, now under the authority of the National Toxicology Program (NTP), should be expanded and expedited with the more active and direct involvement of the NCI. (On a cautionary note, it should be emphasized that this program, which is clearly the direct responsibility of the NCI, was transferred to the NTP in 1978 because of mismanagement and disinterest of the NCI.) Underutilized federal resources, particularly national laboratories, should be involved in carcinogenicity testing programs. The cost of carcinogenicity testing of profitable, and potentially profitable, chemicals should be borne by the industries concerned, and not by the NTP and the NCI and ultimately the taxpayer.

10. The NCI should undertake large-scale intramural and extramural research programs to characterize known carcinogenic exposures, both industrial and lifestyle, in terms of their estimated impact on cancer, and the practical feasibility of their avoidability or elimination within defined early periods.

11. The NCI should substantially expand its intramural and extramural programs on epidemiology research and develop large-scale programs on sensitive human monitoring techniques, including genetic and quantitative analysis of body burdens of carcinogens, and focus them specifically on cancer cause and prevention. The NCI should also take a key role in the design, conduct, and interpretation of epidemiological investigations of cancer by federal and state regulatory and health agencies and authorities.

12. The NCI should develop large-scale training programs for young scientists in all areas relating to cancer cause and prevention.

13. Continued funding by the NCI of its comprehensive cancer centers should be made contingent on their developing strong community out-reach programs in cancer cause and prevention, as opposed to their present and almost exclusive preoccupation with diagnosis and treatment. Centers should also establish tumor registries focused on identifying environmental and occupational carcinogens, and on the surveillance of occupational and other populations at high risk of cancer.

14. With the Congressional oversight and with advice from the NIH Office of Scientific Integrity, the NCI should take early action to disclose information on any interlocking financial interests between its Panel, Advisory Board, advisory committees and others in the cancer establishment, and major pharmaceutical companies involved in cancer drugs and therapy, and other industries. The NCI should also take the necessary precautions to prevent any such future conflicts.

15. The NCI should be enjoined from making or endorsing claims for new "cancer cures" unless these are clearly validated by data on reduced mortality rates and unless they conform to standard FDA regulations on claims for therapeutic efficacy.

16. The NCI should be removed from direct Presidential authority, and reintegrated within NIH, and thus made directly responsive to the scientific community at large and the advice and consent of Congress. Currently, the President appoints the Director of the NCI, who reports directly to the President, the twenty-three member executive National Cancer Advisory Board (NCAB), and three member National Cancer Advisory Panel (NCAP), which controls the policies and priorities of the NCI. The NCAP should be replaced by an executive committee recruited from advisory committees conforming to standard requirements of the Federal Advisory Committee Act for openness and balanced representation. Half of all appointees to NCI advisory committees should be recruited from scientists with credentials and record of active involvement in cancer cause and prevention. Appointments should also be granted to representatives of citizens', ethnic, and women's groups concerned with cancer prevention.

There is no conceivable likelihood that such reforms will be implemented without legislative action. The National Cancer Act should be amended explicitly to reorient the mission and priorities of the NCI to cancer cause and prevention. Compliance of the NCI should then be assured by detailed and ongoing Congressional oversight and, most critically, by House and Senate Appropriation committees. However, only strong support by the independent scientific and public health communities, together with concerned grassroots citizen groups, will convince Congress and Presidential candidates of the critical and immediate need for such drastic action.

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MAMMOGRAPHY RADIATES DOUBTS**

Samuel S. Epstein

It has been widely (and with reason) charged that the makers and marketers of silicone breast implants, and self-interested plastic surgeons, made women their guinea pigs. But what of that other, and greater, scourge of women, breast cancer? There is reason to believe that women are equally ill-served by the cancer Establishment, especially in its unrelenting promotion of mammography.

Breast cancer now strikes one in nine women, a dramatic increase from the one in 20 measured in 1950. This year, 180,000 new cases and 46,000 deaths are expected. Hearings scheduled for February 5 in Washington by the Breast Cancer Coalition, an advocacy group loosely modeled on AIDS activists, could not seem more timely.

The coalition wants more federal funding for the National Cancer Institute (NCI) to increase its research into the causes and treatment of breast cancer, and to improve delivery of breast health care—including diagnostic screening. In pursuing these goals, the Coalition has been co-opted into supporting the policies of the cancer Establishment—the NCI and the American Cancer Society—which is fixated on basic research, diagnosis, and treatment. Cancer prevention receives only an estimated 5 percent of the annual \$1.8 billion NCI budget.

**This was originally published in the *Los Angeles Times*, January 28, 1992, p. B7.

Breast cancer is not the only cancer on the rise. While its incidence has increased 57 percent since 1950, overall cancer has increased 44 percent, now striking one in three people and killing one in four. Male colon cancer is up 60 percent; testis, prostate, and kidney cancer up 100 percent; and other cancers, such as malignant melanoma and multiple myeloma, more than 100 percent. The cancer Establishment trivializes evidence linking these increasing rates with avoidable exposure to cancer-causing industrial chemicals and radiation that permeate our environment—food, water, air, and workplace.

The cancer Establishment maintains, on tenuous evidence, that a fatty diet itself is a major cause of breast cancer, while ignoring contaminants in fat. Carcinogenic pesticides, such as the highly persistent chlordane and dieldrin, which concentrate in animal fats, are known to cause breast cancer in rodents. Elevated levels of DDT and PCBs are found in human breast cancers. An Israeli study found that the breast cancer deaths in younger women recently dropped by 30 percent, despite a substantial increase in consumption of animal fat. This drop followed, and seems linked to, regulations that reduced previously high levels of DDT and related pesticides in dairy products. These pesticides act by mimicking the action of estrogens or by increasing estrogen production in the body, which in turn increases the risk of breast cancer. A related concern is lifelong exposure of all women to estrogenic contaminants in animal fat, because of their unregulated use as growth-promoting additives in cattle feed.

In 1977, the NCI's director of endocrinology, Dr. Roy Hertz, warned, without effect, of breast cancer risks from these contaminants.

More ominous is the enthusiastic endorsement by the cancer Establishment of massive nationwide expansion of X-ray mammography, including routine annual screening. While there is a general consensus that mammography improves early cancer detection and survival in postmenopausal women, no such benefit is demonstrable for younger women.

Furthermore, there is clear evidence that the breast, particularly in premenopausal women, is highly sensitive to radiation, with estimates of increased risk of breast cancer of up to 1 percent for every rad (radiation absorbed dose) unit of X-ray exposure. This projects up to a 20 percent increased cancer risk for a woman who, in the 1970s, received 10 annual mammograms of an average 2 rads each. In spite of this, up to 40 percent of women over 40 have had mammograms since the mid-1960s, some annually and some with exposures of 5 to 10 rads in a single screening from older, high-dose equipment.

Significant studies on radiation risks to the breast have been well known since the late 1960s, including evidence that mammography, especially in younger women, was likely to cause more cancers than could be detected. A confidential memo by Dr. Nathaniel Berlin, a senior NCI physician in charge of large-scale mammography screening in 1973, may explain why women were not warned of this risk: "Both the [American Cancer Society] and NCI will gain a great deal of favorable publicity [from screening, and] . . . this will assist in obtaining more research funds for basic and clinical research which is sorely needed."

Thus, once again, suspect technology was applied to women on a large scale, in spite of clear warning signals and with sufficient knowledge of the likely consequences. (On a smaller scale, but even more ethically appalling, was the use until last April of

industrial polyurethane foam to coat silicone breast inserts, despite clear evidence that its manufacturing contaminants and breakdown products were carcinogenic. As with mammography, no serious studies have been launched to find out what happened to women in whom the foam was implanted, or indeed to women carrying any type of silicone implant.)

The risks of mammography, especially for premenopausal women, persist with the lower radiation doses (about one-half rad per screening) found in modern facilities with dedicated equipment and licensed operators. A large Canadian study conducted from 1980 to 1988 found a 52 percent increase in early breast cancer deaths in women aged 40 to 50 who had 10 annual mammograms, compared with women given just physical examinations. More recent concern comes from evidence that 1 percent of women carry a gene that increases their breast cancer risk from radiation fourfold.

The Coalition should insist that the NCI and American Cancer Society initiate an immediate, large-scale, well-publicized study to further investigate the role of past mammography in increasing breast cancer rates, and to investigate future cancer risk from mammography as currently conducted under widely varying conditions. Women should also be informed of their X-ray exposure and individual and cumulative risks each time they undergo mammography. The Coalition should demand an immediate ban on obsolete high-dose X-ray equipment, and the abandonment of routine mammograms on premenopausal women.

The Coalition should also encourage a crash program to develop and make available safe alternatives to mammography, apart from physical examination. Two that show the most promise are magnetic resonance imaging and transillumination with infrared light. The expansion of mammography should be put on hold, especially in view of the 1991 conclusion of the General Accounting Office that "there are more than enough machines to meet the screening needs of American women."

The Breast Cancer Coalition represents a welcome trend toward active grassroots involvement in public health. However, its current goals are too narrowly defined within the context of existing perspectives and institutional policies. The Coalition needs broader and more radical strategies if it is to reverse the modern epidemic of breast cancer.

NCI REAFFIRMS COMMITMENT TO PREVENTION†

Allegations that the nation is "losing the war on cancer" because of a lack of prevention research were characterized by spokesmen for the National Cancer Institute (NCI) today as old charges, lacking any basis in fact.

NCI officials also disputed the claim by Dr. Samuel Epstein, professor of Occupational and Environmental Medicine at the University of Illinois, and 60 other scientists, that little or no progress has been made in treating cancer, and backed the continuing use of mammography as the best available, early detection tool for breast cancer.

†Press release by the NCI, dated February 4, 1992.

"The NCI's efforts in research in cancer biology, cancer causation, cancer treatment, and cancer prevention and control are well balanced and peer reviewed," said Dr. Richard Adamson, director of the Division of Cancer Etiology, in a prepared statement. Moreover, he added, the Institute is "able to shift research into appropriate programs as science dictates" in order to reduce suffering and death from cancer.

In the coming year, the NCI will spend approximately one-third of its total budget on causation and prevention-related research, including the study of environmental agents in the workplace that may contribute to cancer risk. Over the past two years, NCI has also instituted new guidelines for intensified outreach and prevention programs at the nation's 57 NCI-designated cancer centers. These NCI-supported centers are engaged in all aspects of cancer research from basic research to clinical applications as well as prevention and control.

As part of its prevention efforts, NCI supports numerous studies of the total environment contributing to cancer causation, Adamson said, including studies on viruses, natural and synthetic chemicals, dietary and nutritional factors, fibers, ultraviolet radiation, ionizing radiation, and other factors.

"Unquestionably, however, lifestyle factors contribute to the toll of human cancer," Adamson stressed, "and the single most identifiable causes of cancer—and other diseases—in the United States is tobacco smoking." Numerous independent scientific studies now link tobacco use, particularly cigarette smoking, to lung cancer, as well as cancers of the larynx, oral cavity, pharynx, and esophagus. Tobacco use also has been implicated as a contributing factor in bladder, kidney, and pancreatic cancers.

In a separate statement, Dr. Edward Sondik, deputy director of NCI's Division of Cancer Prevention and Control, criticized Epstein's release of mortality data from the Canadian National Breast Cancer Screening Study, which has not yet been completely analyzed. The data purportedly show that women aged 40 to 49 who have annual mammograms have a 52 percent increase in breast cancer mortality over women who have physical exams only. "The dissemination of this [information] without any scientific basis is unethical," he said.

Although NCI does not view mammography as the ultimate technology for detecting early breast cancer, Sondik said, mammography, coupled with physical exam, has the potential to reduce mortality from breast cancer by at least 30 percent in women over 50. In addition, while studies in younger women have not been conclusive, he said, the evidence to date is that breast cancer screening is prudent for women between the ages of 40 and 49.

ACR REFUTES EPSTEIN'S COMMENTS ON MAMMOGRAPHY‡

Dr. Samuel Epstein's comments on mammography which have been published in several major newspapers nationwide are a mixture of partial truths and outdated data, according to the American College of Radiology (ACR). The ACR, which is a national

‡Press release by the ACR, dated February 4, 1992.

medical specialty association, added that Dr. Epstein's comments could unfortunately discourage women from having regular screening mammograms—the only tests proven to detect breast cancer at an early enough stage to reduce mortality.

The increase in the number of women who develop breast cancer is indeed alarming. Contrary to Dr. Epstein's suggestion that the increased incidence is a recent phenomenon, in fact the increase has been progressive over the past 50 years—long before the routine use of mammography. Extensive research is being done to determine the reasons for the increase. The most recent jump in incidence is primarily an artifact due to breast cancers being detected years earlier through the use of mammography. This produces an apparent increase in incidence. Another reason is that women are living longer and the older a woman, the greater the chance she has of developing the disease.

Dr. Epstein comments that there is no clear evidence that mammography benefits premenopausal women. There are, in fact, studies which show the benefit of screening women under 50. These include the Breast Cancer Detection Demonstration Project conducted by the National Cancer Institute and the American Cancer Society, and the Health Insurance Plan of New York study.

Dr. Epstein also raises the question of radiation risk. Studies of women exposed to high doses of radiation such as those women who survived the atomic bomb blasts in Japan show, along with other studies, that women 35 and older are at no demonstrable risk from radiation exposure to the breast, a fact which particularly applies to the very low doses which are used in modern mammography.

The Canadian study Dr. Epstein mentions is, unfortunately, seriously flawed because mammographic techniques and equipment varied throughout the trial. Quality control measures were not undertaken until late in the study. The researchers themselves noted that the quality of mammography was "poor" to "unacceptable" in the early years of the trial. Moreover, there is evidence that Canadian women with palpable cancers (usually later stage cancers) were encouraged to enroll in the screening trial. Many of these women died from their disease, leading Dr. Epstein to come to the erroneous conclusion that the increase in cancers and deaths was due to mammography screening.

The American College of Radiology has a peer review program which evaluates staff, equipment, and quality control procedures. Mammography facilities which meet the program's stringent requirements are accredited. This program also reviews exposure dose to ensure that mammography is performed at the lowest and safest dose possible while maintaining a high-quality test.

Researchers are constantly looking for other ways of detecting early breast cancer. Dr. Epstein mentions magnetic resonance imaging (MRI) and lightscanning. MRI is expensive and requires that contrast material be injected into the patient. It is one to two years away from the development of a prototype to exclusively evaluate the breast. Lightscanning has been shown to have absolutely no efficacy for detecting early breast cancers.

Investigations are underway to determine possible methods for preventing breast cancer. Numerous researchers are trying to determine its elusive causes. Until its causes are discovered or preventative measures devised, mammography screening provides the safest and best opportunity for detecting breast cancer at a stage at which curative treatment is possible.

Screening by mammography beginning at age 40 is widely accepted. It is recommended by the following organizations:

American Academy of Family Physicians
American Association of Women Radiologists
American Cancer Society
American College of Radiology
American Medical Association
American Osteopathic College of Radiology
American Society of Internal Medicine
American Society of Clinical Oncology
American Society for Therapeutic Radiology and Oncology
College of American Pathologists
National Cancer Institute
National Medical Association

CANCER ESTABLISHMENT CONTINUES TO MISLEAD PUBLIC: DR. EPSTEIN REBUTS NCI/ACR RESPONSES[§]

At a news conference Tuesday February 4, a group of 60-plus prominent scientists and physicians released a statement condemning the National Cancer Institute (NCI) for ignoring or trivializing evidence of how carcinogens in air, food, water, and workplaces are major factors in the cancer epidemic in America. In addition, Dr. Samuel Epstein, professor at the University of Illinois School of Public Health, presented data indicating significant cancer risks in mammograms and their lack of effectiveness for premenopausal women.

The NCI and the American College of Radiology (ACR) responded to these charges in separate statements. The following are Dr. Epstein's rebuttals, which show both groups selectively use scientific data to mislead the public about both the hazards of industrial carcinogens in our environment and of mammograms for younger women:

ACR STATEMENT REFLECTS IGNORANCE, SELF-INTEREST

Contrary to the ACR, the increase in breast cancer incidence since the 1970s has been steeper than in previous decades. Furthermore, these increases exclude effects of aging as they have been age-adjusted.

Also contrary to the ACR, a wide range of studies have failed to demonstrate any benefit from routine mammography in premenopausal women (as opposed to benefits in older women). These include the 1963 Health Insurance Plan of New York, and the 1975 Dutch and 1977 Swedish studies (Skrabaneck, 1985; Bailar, 1988).¹ The 1973–81

[§]Press release, dated February 7, 1992.

¹*Editor's note*—full reference information is available from the author.

Breast Cancer Detection Demonstration Project studies, on which the ACR ineptly relies for alleged evidence of benefit, were “not designed for research purposes, were not carried out in accordance with rigorous research standards, and lack even an appropriate control group” (Bailar, 1988; also Eddy et al., 1988).

The high cancer risk from mammography was well known before the National Cancer Institute and American Cancer Society, with active involvement of the ACR, initiated their large-scale routine screening of premenopausal women in the 1970s. The Biological Effects of Ionizing Radiation committee of the National Academy of Sciences, the world’s leading authority on radiation, warned in 1972 of a “relative risk of about 0.8 percent increase in the spontaneous rate [of breast cancer] per rad” exposure. Thus, routine annual mammography over 10 years of premenopausal women with two rads per exposure (although much higher exposures were then commonplace) would lead to approximately a 20 percent increased cancer risk. Women were never warned of these risks while being falsely assured of benefits. Risks of routine mammography in premenopausal women still persist today, though at lower levels, at the best centers using designated equipment with lower exposures. However, women are still not warned of these risks or of the absence of any benefits (see Epstein, Commentary “Mammography Radiates Doubts,” *Los Angeles Times*, January 28, 1992).

The ACR has misrepresented the recent Canadian study which confirms mammography risks. This study reported a 52 percent increase in breast cancer mortality in young women given annual mammograms as opposed to unscreened controls. A 1991 editorial in *The Lancet* concluded that these findings could not be discounted by the criticisms on randomization and quality of mammography which ACR has resurrected. The editorial further pointed out that the Canadian findings are supported by similar results in several previous studies. *The Lancet* finally concluded that “there is no evidence to support introduction of service mammography for women under 50.” It should be noted that this warning is endorsed by the American College of Physicians and the Canadian Breast Cancer Task Force.

Finally, ACR seems unaware of evidence that transillumination with infrared light scanning is a safe and highly promising alternative to mammography.

Considerations of malpractice aside, the recalcitrance of the ACR reinforces a growing grassroots conviction that cancer is too important to be left to self-interested professionals.

NCI RELEASE REAFFIRMS ITS DENIAL THAT WE’RE LOSING THE WAR ON CANCER

As detailed in a statement by 60 plus distinguished national scientists at a Washington, D.C., news conference on February 4: cancer rates are escalating; our ability to treat and cure cancer, apart from childhood and other rare cancers, has not improved for decades; and our environment, air, water, food, and workplace have become permeated with industrial carcinogens.

Meanwhile, the NCI and the American Cancer Society (ACS) have trivialized the evidence for increasing cancer rates and their relation to avoidable exposure to industrial carcinogens. Instead, together with the chemical industry, they focus on dietary fat itself (ignoring increasing contaminants, including pesticides), and smoking (ignoring

increasing lung cancer rates in nonsmokers, and the important role of occupational exposures and urban air pollution) as the predominant causes of the cancer epidemic.

Furthermore, the NCI and ACS, with their fixations on diagnosis, treatment, and basic research, are indifferent to cancer cause and prevention, which accounts for only five percent of the NCI \$2 billion budget (see budget line item of \$90 million for Cancer Prevention and Control), and not 33 percent as the NCI alleges. The position of the NCI and ACS on prevention is further illustrated by their recent silence while the administration rolls back regulations designed to reduce avoidable exposure to industrial carcinogens, including the 1958 Delaney law banning the deliberate addition of any level of carcinogens to food; overwhelming evidence supports the scientific validity of this law.

The NCI and ACS position on prevention is compounded by their exaggerated claims on ability to treat and cure cancer. As detailed by authorities including the General Accounting Office (1987), these claims reflect gross statistical manipulation, including the use of "relative survival" rather than mortality rates.

The statement by the 60 plus scientists calls for urgent reforms in federal cancer policies. These reforms must ensure that the NCI gives greater emphasis to cancer prevention, rather than to chasing the elusive but ever-promised cure for cancer, coupled with continuing oversight to ensure compliance. These reforms demand drastic legislative action and strong grassroots support.

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