

ing is referred to as 'prophylactic mastectomy' because it reduces the risk of contralateral breast cancer (by approximately 95%). Basu and colleagues have chosen to refer to this as 'mastectomies of healthy breasts'.

The usually quoted lifetime risk of contralateral breast cancer in patients without high risk family history is between 20 and 25%. This compares with a lifetime risk of a first breast cancer of approximately 1 in 8 in the UK.

In the key publication referred to in the article (Early Breast Cancer Trialists' Collaborative Group, 2005), the annual contralateral breast cancer rates were in the order of 2% after polychemotherapy and 0.4%/year after tamoxifen. The tamoxifen data are often used as evidence of a very low risk when prophylactic surgery is discussed and it sounds reassuring if you are a 30-year-old who has had breast cancer, by the time you are 65 years old you will have had a cumulative risk of 14% at least if you have oestrogen receptor-positive breast cancer and you take tamoxifen. If you have a tumour that is not oestrogen receptor-positive your annual risk after chemotherapy is 2% so that by 65 years of age the cumulative risk may be 70%.

In the Early Breast Cancer Trialists' Collaborative Group (2005), the number of contralateral breast cancers actually seen over a median follow-up of just 15 years in patients under 50 years of age who had chemotherapy (including oestrogen receptor- and progesterone receptor-positive disease) was 14%.

For a young patient an annual risk of recurrence of 2% is not trivial as they have a lifetime of cumulative risk ahead of them.

Prophylactic mastectomy is appropriate for some well-informed patients, but there are concerns about finance and capacity. It is not constructive to patronise or use pejorative language. What is required is greater focus on alternative preventative strategies, sensible access to better screening techniques such as magnetic resonance imaging and a discussion with commissioners on how we make sensible management choices available to informed patients at risk.

Johnathan Joffe

*Macmillan Consultant in Medical Oncology
Calderdale & Huddersfield NHS
Foundation Trust
Huddersfield Royal Infirmary
Huddersfield HD3 3EA*

Early Breast Cancer Trialists' Collaborative Group (EBCTCG) (2005). Effectiveness of chemotherapy and hormonal therapy for early breast cancer on recurrence and 15 year survival: an overview of the randomised trials. *Lancet* 365: 1687-717

Sir,

We would agree with Dr Joffe's comment that prophylactic (risk-reducing) mastectomy is entirely appropriate for some well-informed patients. The difficult question is: what level of risk of contralateral cancer do we quote?

In our own discussions with patients we use an annual cumulative risk of 0.5% per annum as the baseline risk for those with oestrogen receptor-negative disease, and 0.25% per annum for those with oestrogen receptor-positive disease on tamoxifen or an aromatase inhibitor. This is because we believe the 2% per annum quoted figure to be an overestimate, as we think it includes local recurrence as well as contralateral primary disease. Many well-informed women will indeed choose risk-reducing contralateral mastectomy based on those baseline 0.5% and 0.25% odds, especially if there is an additional risk factor such as family history or lobular cancer.

NN Basu/DG Evans/L Barr

*National Oncoplastic Breast Fellow/Professor of Genetic Medicine/Consultant Surgeon
Nightingale Centre and Genesis Prevention Centre
University Hospital South Manchester
Manchester M23 9LT*

Privatization of medical training: the shape of things to come

Sir,

The government, faced with a debt-ridden NHS, has long been outsourcing services to private companies. Despite the fact that they continue to maintain a motto of 'free at the point of delivery', the sad fact is that current changes are disturbing its foundations.

Across the UK, medical students are facing tougher capital costs than ever. With a rise in tuition fees, now £9000 per annum, many a high school leaver who is keen on medical practice is forced to look at alternative options. Despite these con-

cerns, the UK's first private medical school has recently been established at the University of Buckingham, with fees totalling £35 000 a year. As a medical educator, I am concerned by the likely discrepancy that this will cause in terms of training delivery. Many medical schools, like the NHS, are faced with financial problems. Despite this, they strive hard to provide appropriate training to ensure their graduates will be safe and effective working doctors.

With privatization of medical training, there will no doubt be a difference in training standards, with such an establishment being able to afford, for example, more research advances or the latest technologies designed to supplement learning, technologies such as mannequin or virtual patient simulation which are not always common place at all schools. If other students are then disadvantaged as a result this may impact not only on their career progression, despite being equally capable, but also on patient care in the future.

As doctors we all need to see the potential harm that privatization may cause and instead of giving the green light to such ventures, be quick to pull the plug on the grave disparities that will result.

Neel Sharma

*Honorary Clinical Lecturer
Centre for Medical Education
Barts and the London School of Medicine
and Dentistry
London E1 2AD*

Correspondence

If you would like to comment on any of the articles in *British Journal of Hospital Medicine*, please write in no more than 250 words to:

Professor Rob Miller
Editor-in-Chief, BJHM
c/o Rebecca Linssen, MA Healthcare
St Jude's Church
Dulwich Road
London SE24 0PB

email: rebecca.linssen@markallengroup.com
fax: 020 7978 8316