Perspectives on breast cancer in Arab populations

We read with interest the Review on breast cancer in Arab populations by Chouchane and colleagues,[1] and offer comments on two issues about which some readers might have confusion.

Firstly, the authors suggest that reported incidence of breast cancer in Arab women is erroneously low because of cases going unreported in cancer registries. It is true that cancer registration in the Arab world is woefully inadequate, and nothing said here should be construed as discounting this fact. However, several high-quality registries exist that include Arab populations. Cancer Incidence in Five Continents Volume X,[2] the gold standard for cancer registries, judged data from Algeria, Bahrain, Egypt, Kuwait, Libya, Qatar, Saudi Arabia, and Tunisia worthy of inclusion. Breast cancer incidence in all these registries is substantially lower than those seen in registries in the USA and Europe. Relatively low breast cancer incidence in Arab women is affected by their reproductive patterns (high fertility, early pregnancies, and increased breastfeeding), but these patterns are changing. The evolving trends in reproductive patterns in Arab women portend higher breast cancer incidence as these populations age—ie, young Arab women will have higher breast cancer incidence than did their grandmothers and mothers at the same age. Data from the Israel Cancer Registry, which maintains separate records for Jews and Arabs living in Israel, strongly support the contention that lower breast cancer incidence in Arab women are real and not the result of widespread under-ascertainment of cases. In personal discussions with personnel of the Gharbiah Cancer Registry (Egypt), the Sousse Cancer Registry (Tunisia), and the Israel Cancer Registry, we have been assured that very few breast cancers are missed among the Arab populations these registries cover—ie, most breast cancers (even those with late diagnoses) are ultimately captured in the registry data.

The second issue that we would like to address is the recommendation that mammographic screening in Arab women start at younger ages because the average age of breast cancer is lower than in western countries. We have addressed this issue in other publications.[3,4] The entire populations of Arab countries are generally skewed toward younger ages, so a lower average age of breast cancer cases in Arab countries does not mean that younger Arab women are more likely to have breast cancer. In Israel, breast cancer incidence in 40–44-year-old Arab women is less than half that seen in the comparable Jewish population, with the incidence in Jewish women being very similar to that seen in the USA—incidence in Arab women resembles more closely the incidences seen in Egypt and Jordan.[5] In contemplating a mammographic screening programme, the average age of cases is less relevant than the age-specific incidence that determines the yield of the programme and affects the harms-to-benefits ratio of screening for the population as a whole. Therefore, there is not the evidence to support a recommendation to start mammographic screening earlier in Arab populations simply due to a lower average age of breast cancer in these populations.

We declare that we have no conflicts of interest.

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Time for evidence-based e-cigarette regulation

The alarm bells being rung in your recent Editorial[1] on e-cigarettes are unsupported by present data. The Editorial points to a recent US Centers for Disease Control and Prevention (CDC) report,[2] which claims that e-cigarettes usage in teenagers has doubled from 1·1% in 2011 to 2·1% in 2012, to support the statement that e-cigarettes are "becoming a gateway product, attracting more young people to begin smoking".

However, careful reading of the CDC report shows that there are no real data to support the notion that young people are using e-cigarettes and then transitioning to smoking conventional cigarettes. The report did not suggest that regular daily use had spiked in teens, but rather that the number who had ever tried one puff in the past month—which is essentially a measure of experimentation—had increased. Experimentation with a novel product like e-cigarettes is not unusual, particularly in children. The CDC report provided no evidence that young people are actually taking up this behaviour and becoming regular users of e-cigarettes. Of note, of those who experimented with e-cigarettes in 2012, 90·6% were already tobacco smokers.[3] The fact that experimentation was mainly occurring in young people who already smoke cigarettes is not necessarily a bad thing, if it can reduce

the chance of young people becoming lifelong cigarette smokers.

The proportion of non-smoking young people who experimented with e-cigarettes in the past month was small, at 0·5%, and thus does not prove transition to cigarette smoking. No cases of non-smoking young people beginning to use e-cigarettes, becoming addicted to nicotine, and then becoming a regular cigarette smoker, were documented. Furthermore, data from a new study confirms the conclusion of the CDC report that experimentation of e-cigarettes in non-smoking high school students is very low, at about 0·4%, and that none of the students adopted e-cigarettes as a regular behaviour and then went on to become a regular cigarette smoker.[3] Overall, these data show that use of e-cigarettes is not popular among non-smoking young people.

Another unsupported statement is that "e-cigarettes also pose a serious danger of renormalising smoking". No study has supported concerns that the use of e-cigarettes in smoke-free areas might undermine smoke-free laws. Most people have no difficulty differentiating vapour from smoke. All testing of vapour so far has shown no evidence that use of e-cigarettes results in exposure to inhalable chemicals that would warrant health concerns by common safety standards.[4] Therefore, there is no justification for extending existing "clean air" regulations to include e-cigarettes. Furthermore, use of e-cigarettes where smoking is prohibited might encourage smokers to make the switch to a product that could save their health and their lives, thereby helping to denormalise (rather than renormalise) smoking by reducing the overall number of smokers. Use of e-cigarettes is a gateway out of smoking.

Nevertheless, we are in no way arguing here that regulation is not needed. Just the opposite. Regulation is necessary to ensure that e-cigarettes do not become popular among non-smoking young people and to consider restrictions about use of e-cigarettes in places frequented by very young children. Likewise, it is prudent to institute controls on marketing of e-cigarettes to non-smokers and to apply the same prohibition on sales to children and young people as for tobacco products.

As a final point, we see no need to apply the strict regulations in use for pharmaceutical products that will marginalise e-cigarettes by making them unattractive to smokers and less competitively priced compared with tobacco products. Reasonable regulation of these products should simply follow good manufacturing practice policies thus ensuring that the liquids used in e-cigarettes are produced in a quality manner, do not contain contaminants or impurities, are accurately labelled, and are held under conditions to prevent adulteration.[5]

Present scientific evidence supports the contention that regulators, along with public officials, health authorities, and anti-smoking groups, should embrace e-cigarettes as an important strategy in their efforts to reduce smoking and its related health effects.[6] It is irresponsible to mislead the public into believing that e-cigarettes pose an extraordinary danger to consumers and young people when there is absolutely no evidence to support that claim.

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Adjuvant treatment for resected pancreatic adenocarcinoma—still an unresolved issue

In Wei-Chih Liao and colleagues'[1] recent Article, the authors compared different adjuvant treatments for resected pancreatic adenocarcinoma. They specifically compared adjuvant treatment with fluorouracil, gemcitabine, chemoradiation, chemoradiation plus fluorouracil, and chemoradiation plus gemcitabine in terms of overall survival and toxic effects. The authors acknowledged that it was difficult to make direct comparisons of certain treatments because of an absence of head-to-head trials and measures of survival varied between different trials. They have attempted to overcome this by use of a Bayesian network meta-analysis.

The authors conclude that chemotherapy with fluorouracil or gemcitabine is the optimum adjuvant treatment for pancreatic cancer and that "adding chemoradiation to chemotherapy provides little survival benefit, but increases toxic effects and therefore future trials with chemoradiation are probably unwarranted".[1] Liao and colleagues