short durations, on circumscribed populations and under tightly controlled conditions.

A key, but often overlooked, issue is whether the results of studies are externally valid (generalisable). Indeed, the evidence base that dictates clinical practice and health policy should comprise data that are both internally and externally valid.

We do not suggest that epidemiological modelling replace longitudinal studies (in fact, modelling depends critically on robust prospective data); rather, it complements these studies by providing a means to assess their external validity.

We are also mindful of the limitations of epidemiological modelling, as outlined in our article, and acknowledge the importance of ensuring rigour in the methods.

Our article dealt with generating the data needed for sound economic evaluation, by taking into account the long-term benefits, risks and costs of treatment strategies, and “real-life” health service conditions. This is distinct from the issue of whether “conditional listing” on the Pharmaceutical Benefits Scheme should be implemented for drugs that are yet to be proven cost-effective.


Screening mammography and mortality

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TO THE EDITOR: In a recent letter in the Journal, Rodger writes that breast screening is unlikely to affect overall mortality and notes that this “gives the lie to the conclusions of Olsen and Gøtzsche’s overview, which are based only on overall mortality”.

English is not my first language, but according to my English–English dictionary “give the lie to” means either “to disprove” or “to accuse of lying”, and a related adjective is “mendacious”. In actual fact, however, in our Cochrane Review, we carefully analysed both breast cancer mortality and all-cancer mortality. We found breast cancer mortality to be an unreliable outcome that is biased in favour of screening. For deaths ascribed to any cancer, including breast cancer, we found a relative risk of 1.02 (95% CI, 0.95–1.10) for the two trials with medium-quality data, and a relative risk of 1.00 (95% CI, 0.91–1.10) for the only trial with poor-quality data that reported all-cancer mortality. If it were true that screening reduced breast-cancer mortality by 30%, as some Swedish researchers have claimed, then the expected relative risk for all-cancer mortality should not be greater than 0.95. These findings should raise concern rather than complacency.

Another, recent indication that things are not what they purport to be is provided by the results of the large Two-County study. A Swedish overview of the randomised trials reported a 10% reduction (95% CI, 0.73–1.11; absolute reduction, 5.0/1000 to 4.5/1000) in breast-cancer mortality for one of the two counties, whereas the authors of the Two County study reported a 24% reduction (95% CI, 0.62–0.93; absolute reduction, 5.7/1000 to 4.3/1000), with the same type of statistics, within the same age group of women (40–74 years), and after a similar follow-up (1.2 v 1.3 million women-years).

The conclusion in our Cochrane Review is: “The currently available reliable evidence does not show a survival benefit of mass screening for breast cancer (and the evidence is inconclusive for breast cancer mortality).” I would not have expected Rodger, as an editor of the Cochrane Breast Cancer Group that approved and published our Cochrane Review, to talk about “giving the lie” to our results.

Competing interests: None identified. The views expressed are mine and are not necessarily the views or the official policy of the Cochrane Collaboration.

A bitter pill to swallow

AN ELDERLY PATIENT with diabetes presented with oesophageal obstruction after taking a regular dose of metformin. A lateral neck radiograph confirmed the presence of an obstruction in the upper oesophagus. The patient underwent rigid oesophagoscopy, at which time the tablet, complete with packaging, was removed (see Box). The patient went on to make a full recovery.