

answer requires a prospective randomised trial for this specific population—such trials are currently underway in both North America (CALGB 49907 trial) and Europe (CASA Adjuvant Trial).

The EBCTCG meta-analysis does not reveal the benefit from adjuvant systemic therapies for an individual patient presenting today with a more detailed molecular profiling of her tumour. For example, the 2000 overview concludes that chemotherapy provides additional benefit independent of that derived from tamoxifen alone in postmenopausal women with oestrogen-receptor-positive breast cancer, but perhaps the size of the benefit depends on the overexpression of human epidermal growth factor receptor 2 as suggested by a recent subset analysis of a large randomised trial (Intergroup 0100 trial).⁶ The future EBCTCG meta-analyses might substantiate such findings if molecular characteristics are available in large patient cohorts.

Since their inception, the EBCTCG overviews have been extremely useful and have confirmed the absolute size of benefit over time from adjuvant chemotherapies and hormonal therapies. These survival gains are central to the significant improvements in mortality seen over the past decade in the USA and the UK,⁷ and will affect more than 1.15 million women diagnosed worldwide with breast cancer annually⁸ who might have access to evidence-based treatment. But how much new information can we squeeze out of this database of older treatment strategies? What is the added value for continuing this exercise as it is, with an upcoming 20-year overview? As the rate of relapses after the first 5 years in the treated and control arms were similar from years 5–15, they are unlikely to change in years 15–20, thus making it improbable that the corresponding survival curves will suddenly become convergent. As this quinquennial collaboration of trialists continues, can we look forward to seeing meta-analyses that will focus on modern chemotherapeutic strategies (eg, incorporation of taxanes in combination or sequentially with an anthracycline; trastuzumab for tumours that overexpress

human epidermal growth factor receptor) and hormonal strategies (eg, luteinising-hormone-releasing-hormone agonist plus tamoxifen in premenopausal patients with oestrogen-receptor-positive disease; an upfront or sequential aromatase inhibitor in postmenopausal oestrogen-receptor-positive breast cancer).

The present study does help the clinician make treatment recommendations. However, further gains will be made by understanding the molecular heterogeneity of breast tumours,^{9,10} and treating more appropriately both the woman's risk of recurrence and the specifics of her tumour. Adjuvant therapy's benefit has been proven. The future challenge is to cure more women with early-stage breast cancer. Mind the widening gap.

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Laparoscopic-assisted resection of colorectal carcinoma

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In this issue of *The Lancet*, Pierre Guillou and colleagues report short-term endpoints from the UK Medical Research Council (MRC) trial of conventional versus

laparoscopic-assisted surgery in colorectal cancer (the CLASICC study). CLASICC is a multicentre randomised trial comparing five different colorectal operations for

cancer. It is one of two such trials¹ addressing the important question of whether patients with colorectal cancer will benefit from a minimally invasive surgical approach to their disease. The advent of laparoscopic surgery has revolutionised general surgery in the past 15 years. The proven advantages of minimally invasive surgery include less pain, quicker return of gastrointestinal function, shorter hospital stay, fewer wound complications, quicker postoperative recovery, and less need for immunosuppression. Laparoscopic colon resection has not been adopted as quickly by the surgical community as have other laparoscopic procedures. In part, the technical challenges of the operation have prolonged the learning curve and minimised enthusiasm. In addition, major concerns about the oncological effects of the operation in patients with malignant disease have limited its application in patients with colorectal cancer. Early reports of port-site metastases,² as high as 21% in one report,³ raised serious concerns about the role of laparoscopic resection of colorectal cancer. Given that patients with benign colorectal disease clearly experience the advantages of a minimally invasive approach to their disease,⁴ addressing the issue in patients with colorectal cancer has taken on a fresh urgency.

Many small studies⁴⁻⁷ have shown shorter hospital stays, less pain, and decreased need for analgesia in patients undergoing laparoscopic resection for colorectal cancer, while margin lengths and number of lymph nodes harvested (surrogate endpoints for adequate resection) have been similar in the two groups of patients.⁴⁻⁹ These promising data led to three large randomised trials in addition to CLASICC.^{1,10-12} Results from the Lacy¹² and Clinical Outcomes of Surgical Therapy (COST) Study Group¹ trials have been published and show longer operative times, less intraoperative blood loss, quicker return of gastrointestinal function, less pain and less narcotic use, and shorter hospital stay in the laparoscopic group. These results are confirmed by CLASICC. Conversion rates in CLASICC and COST were similarly high, around 20%, and complication rates were similar in the open and laparoscopic groups in these two studies. Lacy¹² had a lower conversion rate (11%) and smaller complication rates in the laparoscopic group than in the open group. His improved results might have been partly because

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his was a report of only one surgeon's experience and that surgeon was clearly past the learning curve, while COST and CLASICC were multicentred. Although surgeons needed to do 20 laparoscopic colon resections before enrolling patients in COST and CLASICC, 20 patients might be too few for surgeons to have advanced sufficiently along their learning curve.

CLASICC and COST¹ evaluated quality of life and found no significant advantages with a laparoscopic approach.¹³ Possibly, patients with cancer are most concerned about their malignancy and survival rather than daily quality of life. All three studies found similar pathological endpoints in the laparoscopic and open groups when evaluating number of lymph nodes harvested and resection margins. Thus far, the only concerning finding is the possibility of a higher incidence of positive circumferential resection margins in patients with rectal cancer undergoing laparoscopic anterior resection. CLASICC is the only randomised study evaluating patients with rectal cancer, so this finding will need to be further investigated, especially focusing on results early during the learning curve. The most important finding from the COST and Lacy¹² studies is that there were no differences in survival between

laparoscopic and open resection except for patients with stage III disease, who, in Lacy's study, had improved survival for unknown reasons. This long-term endpoint was not reported in CLASICC, but it will be important to see whether CLASICC's results support those of the COST and Lacy trials.

Until recently, because of the concerns about oncological effects, surgeons have agreed to offer laparoscopic colon resection in colorectal cancer only to patients enrolled in a clinical trial. CLASICC, with the COST¹ and Lacy¹² trials, shows that patients with colorectal cancer can be offered laparoscopic-assisted resection. These studies provide data supporting the safety of laparoscopic colectomy for colorectal cancer for complications and survival, while offering moderate advantages in terms of recovery. It is important that the surgeons are well trained both in advanced laparoscopic techniques and in oncological surgical principles. Preoperative work-up should focus on identifying patients who are at high risk for conversion. Because of the increased operative times, length of stay, and complications seen in these patients, serious thought should be given to doing the operation in an open fashion. In appropriately selected patients who are operated on by experienced surgeons, laparoscopic surgery for colorectal cancer may be the new gold standard.

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Enhanced access to emergency contraception

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Despite its undisputed safety and efficacy, enhancing women's access to emergency contraception has been controversial.^{1,2} Some of this controversy is related to the anomalous position of emergency contraception in the family-planning repertoire: anomalous because it is used after sex.³ At the same time, some developments in emergency contraception, aimed at combating teenage and unwanted pregnancy, have been reported in particularly lurid terms by the mass media, conflating concerns about sexual morality, inappropriate use of contraception, and the spread of sexually transmitted infections.² Against this background, it is interesting to note the findings from a recent study providing evidence of the broader effects of emergency contraception on key public-health issues.⁴ Tina Raine and colleagues⁴ randomly assigned 2117 young women

aged 15–24 years to either pharmacy access to emergency contraception without a prescription, advance provision of emergency contraception, or usual care (requiring a visit to a clinic). Over the 6-month follow-up, the authors report that women in the advance provision group were almost twice as likely to use emergency contraception (37.4%) than those who had pharmacy access (24.2%) or usual care (21%). Interestingly, pregnancy rates and rates of new sexually transmitted infections were similar in all the groups. Furthermore, easier access to emergency contraception did not appear to affect regular contraceptive use or risky sexual behaviours.

Like Litt,⁵ we believe this is important new evidence. Data from a recent study in Scotland reached similar conclusions.⁶ In that study, women aged 16–29 years