

# Max Pemberton



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## The ifs and buts of breast screening

In an uncertain world, we want to believe in the certainty of medicine: that it is omniscient and operates in absolutes. In reality, this is far from the truth. The world of medicine reflects the world we live in: constantly in flux with multifarious contradictions.

Scientists relish this fact. Hypotheses are proffered, challenged, investigated and proved or disproved in an ongoing, dynamic process. However, for those on the outside, this can be bewildering. We are told one thing one minute, only for it to be ridiculed the next. With its definitions and protocols, medicine serves to give the illusion of stability when, in truth, doctors are all too often unsure.

The furore around breast screening perfectly illustrates this. It began when the Government's cancer "tsar", Prof Sir Mike Richards, announced that he is setting up an independent review of the NHS programme. He has also ordered that patient leaflets, which explain the screening programme, be rewritten to take into account claims by some experts that the benefits have been exaggerated.

Understandably, this has prompted widespread confusion. The issue of breast cancer is always emotive. When I worked in breast surgery, I saw first hand the horrors of this disease on sufferers and their families, and it is vital that we do everything we can to treat and prevent it. But the debate over screening has been raging for some time within the medical community. I remember attending a lecture on this issue when I was at medical school more than 10 years ago.

The NHS screening programme was



Breast screening: Are women being over-diagnosed and over-treated?

Introduced by the Thatcher government following the 1987 Forrest Report, which recommended a national screening programme for breast cancer for women aged between 50 and 74. The report was based on the most up-to-date research. But, since then, by comparing countries that have a screening programme with those that don't, evidence has emerged suggesting that the steady fall in mortality in Western countries is not due to the screening programme, but to improved

treatment and service provision.

If this is shown to be true – and it's still a big if – then this would mean we are needlessly screening thousands of women. And there is an argument that many of the tumours detected by screenings would not actually have developed into a life-threatening cancer.

For every screening test, whatever the disease, there is a margin of error. How good a test is can boil down to two things. The first is sensitivity, which measures

how good the test is at giving a positive result in those who have the disease. The second is specificity, which refers to how many of those tested are disease-free and test negative.

Now, if you act on the results every time a test records a positive – in the case of breast cancer by doing invasive surgery or giving radiotherapy or chemotherapy – the sensitivity and specificity has to be very high (as near to 100 per cent as possible) to warrant a national screening programme. If it's not sensitive enough, you'll be giving women false reassurance when, in fact, tumours are being missed. Similarly, if it's not specific enough, you'll be needlessly treating people, with all the associated risks that treatment brings. It is this that is concerning some experts.

They argue that women are being over-diagnosed and over-treated because screening is not specific enough. It can pick up breast abnormalities that may look worrying when biopsied but are actually harmless. It's a balancing act between saving lives and not causing harm by needless treatment. While doctors are used to adapting to changes in evidence, this is little consolation to women who worry about the disease.

It is perfectly sensible to have an independent review of the research, but I can't help but think of the women who have had treatment, or are facing treatment, or those who are deciding if they should go for screening. The fact that the current debate waging in the medical establishment is part of the reflexive process that underpins science is of little comfort to them.

## Let's deal firmly with those who fail in patient care

Health Secretary Andrew Lansley should be congratulated – and it's not often I say that – for his announcement last week that widespread spot checks on hospitals and care homes will be introduced in a drive to improve standards. The checks will be

undertaken by the Care Quality Commission (CQC). It comes after the Government reviewed the findings of the first wave of unannounced visits to care of the elderly wards in the summer. Over half the hospitals inspected had problems, particularly in relation to issues around patient dignity.

Spot checks are the way to tackle this and weed out bad practice and serious failings. But, they will only have any meaning if the CQC – often felt by those campaigning for improved standards as toothless – act on what they find. We don't need endless reports and bureaucratic stalling. If it will work, the CQC will

have to use its muscle. Those in charge of wards and hospitals found to be falling must be held accountable and dealt with firmly.

Max Pemberton's new book, *The Doctor Will See You Now* is published by Hodder. To order a copy, call Telegraph Books on 0844 871 1515

## Good news for vampires...

Fans of the fantasy sci-fi series *True Blood*, beware. In the show, which has won a Golden Globe and an Emmy and is currently on Channel 4, vampires live openly among us after the invention of synthetic blood means that they and humans can coexist. Well, now it emerges that

scientists at Edinburgh and Bristol universities have been developing artificial blood, which could be available for use within three years. As science fiction becomes science fact, is it only a matter of time before we find out who are the vampires? I've had my suspicions about a few people for a while now.

## A light café: the perfect place to lose those 'winter blues'

Could Scandinavian-style "light cafés" help combat the winter blues? With clocks going back (at least for now) and nights drawing in, some specialists are arguing that coffee bars, which provide high-strength lighting along with their lattes, might help the one in five people who suffers from seasonal affective disorder (SAD), a type of depression triggered by lack of light in winter.

Light cafés have taken off in Sweden, which has nearly a million SAD sufferers and where winter gloom is a far greater problem than in the UK. Stockholm, for example, gets only five hours of daylight in the winter months. But the city's commuters can stop off in cafés, such as the Iglo, and sit bathed in UV-free lighting to the strength of 3,000 lux (the technical measure of brightness).

This intense light, which compares with the 2,500 lux emitted by domestic or office lighting, simulates natural light and is thought to correct the hormone imbalance that causes SAD, although its effectiveness has not been conclusively proved.

Dr Victoria Revell, an expert in chronobiology (the study of circadian rhythms) at the University of Surrey, says that the cafés would benefit British SAD sufferers.

"They are beneficial both physiologically and socially. Using light therapy in this way can help our sleep patterns, energy levels and performance."

An estimated 7 per cent of Britain's population suffer from SAD, with a further 17 per cent experiencing a milder form of the condition, commonly known as the "winter blues". SAD kicks in as the days get shorter, the loss of natural daylight triggering depressive symptoms such as lethargy, a lack of interest in sex and sleep problems.

"In the winter, I have no motivation, I have a low mood and take people's comments very personally," says Susan Willis, who has SAD.

Dr Revell explains: "One key role of light is to synchronise our circadian body clock to the 24-hour day." SAD sufferers, she says, require a higher light intensity to regulate their body clocks. In the winter, when light levels are lower, they produce too much melatonin (the hormone which helps us sleep) and less of the "feel-good" hormone, serotonin.

The latest thinking is that the disorder has genetic origins. In America, for example, research suggests that mutations in a gene associated with melanopsin – a light-sensitive pigment in the retina of the eye thought to help regulate our circadian rhythms – may be involved.

Willis, 38, a marketing manager from Derbyshire, uses a lightbox every morning to help with symptoms. The NHS does not provide light therapy (also called phototherapy) for SAD and says that the evidence for its effectiveness is still unclear. It offers cognitive behavioural therapy and antidepressants instead.

Not all doctors agree: the Royal College of Psychiatrists recommends 30 minutes to one hour of light therapy daily, which some studies show is effective for 50-85 per cent of cases. Commercial lightboxes vary in price from £35 to £200, depending on the light intensity delivered, but 2,500 lux is the minimum needed to work. Some light devices are portable for travel or office use.

SAD sufferers are also advised to spend as much time as possible outside in natural daylight and to keep active.

For Susan Willis, light cafés sound much more fun. "Imagine walking along a dark street and seeing a light café where you can also get a warm coffee. Just thinking about it makes me smile."

Jo Carlowe

The Seasonal Affective Disorder Association: [sada.org.uk/](http://sada.org.uk/)  
For light box information, see [www.lumie.com](http://www.lumie.com)