

ABSTRACTS

BREAST CANCER AND HRT

Recent rather confusing reports in the lay press comment on the fact that a large trial of hormone replacement therapy in women who previously had breast cancer was stopped early. Yet another nail in the coffin of HRT, which has been a major earner for pharmaceutical companies, and a source of comfort for many women over the years. However, what was not stressed sufficiently in the lay press was that this trial took place in women who had already been treated for breast cancer.

A report in the *Lancet* clarifies the issues. In the 1990s, 2 randomised clinical trials looking at the safety of HRT for women with previous breast cancer were started in Scandinavia — HABITS (hormonal replacement therapy after breast cancer — is it safe?). Women who had previous breast cancer were allocated either to HRT or to the best treatment without hormones. The main endpoint was any new breast cancer event.

Until September 2003, 434 women entered the trial. There was at least one follow-up report for 345 of them. After a median of 2.1 years, 26 women in the HRT group and 7 in the non-HRT group had a new breast cancer event. Most women were on treatment when this occurred. The HABITS trial was stopped because women with a history of breast cancer allocated to receive HRT for menopausal symptoms had an unacceptably high risk of breast cancer compared with breast cancer survivors who received the best symptomatic treatment without hormones. The women on active treatment have been advised to stop this. But, women on the trial will be followed up for at least 5 years after randomisation, and the steering committee of the HABITS trial will continue to collaborate with other similar studies.

Holmberg L and Anderson H, for the HABITS steering and data monitoring committees. *Lancet* 2004; **363**: 453-455.

TRAINING FOR RURAL PRACTICE

Distribution of doctors is a hot topic in South Africa, not least because of the numbers we lose to what are seen as greener pastures. It is interesting to find that Australia, one

of the largest recruiters of South African doctors, has no more success in doctoring its rural areas than we do. According to an editorial in a recent edition of the *Medical Journal of Australia*, the country's medical workforce is distributed unevenly and there is reduced access to medical services in remote areas, where people have the highest morbidity and mortality. Recognising this, and that the work of rural general practitioners is generally more complex than that of their big city colleagues, Australia has introduced a suit of initiatives to encourage more doctors to chose a career in the outback.

A paper by Hedley Peach and colleagues looks at the case for more year-long internships outside metropolitan areas. Their object was to determine whether medical graduates who spent their intern year at a rural hospital were more likely to end up practising in a rural area than were those who trained in the city. They compared Ballarat Base Hospital, classified as being in a rural, remote zone, and hospitals in Melbourne and Geelong, which were metropolitan. They looked at 57 Victorian medical graduates who completed their internships at Ballarat Base Hospital and compared them with 126 age and sex-matched controls who were interns in metropolitan hospitals between 1989 and 1997. The outcome was where they were practising in 2002.

The authors found that more Ballarat Base Hospital graduates were practising as GPs outside metropolitan areas than metropolitan interns. Very few in each group had chosen to specialise. Their conclusion was that regional interns are a good source of non-metropolitan GPs, particularly locally.

This does not, however, immediately prove that making people do internships in rural areas will lead to rural practice. As the authors point out, cohort studies are needed to examine this point. It may well be that those choosing rural internships are from the area anyway and have reasons to remain there. Similar studies in Canada and North America have also not clarified this point.

Peach HG, *et al.* *MJA* 2004; **180**: 106-108.

WHEN TO EAT

With the ever-rising incidence of obesity, more advice about diet is being sought and offered. A recent article in the *Journal of Nutrition* suggests that timing of eating influences how much a person will eat in a day. We know that circadian and diurnal rhythms influence food intake, and early research suggests that meal sizes increase during the day, while the intervals between meals and the length of time before a person starts feeling hungry again, decrease.

The authors of this paper hypothesised that eating early in the day would tend to decrease overall intake, while eating later in the day would increase it. They examined the daily intakes of 375 men and 492 women and reanalysed previously obtained 7-day diet diaries. The total and meal intakes of food, the amounts of macronutrients eaten and the density of intake which occurred during five 4-hour periods were identified and related to overall and meal intakes during the day. They found that the more someone ate early in the day, the less they ate later in the day. The converse was also true: eating later in the day resulted in higher overall intake for that day.

It would seem that a good breakfast is still the best way to start the day.

Castro JM. *J Nutr* 2004; **134**: 104-111.

TUBERCULOSIS EPIDEMICS DRIVEN BY HIV: IS PREVENTION BETTER THAN CURE?

Christine Currie and colleagues from the University of Southampton and Communicable Diseases at the World Health Organisation compared the benefits of tuberculosis (TB) treatment with those of preventing TB and HIV in controlling TB in regions of high HIV prevalence. They compared the effectiveness of TB chemotherapy with three strategies for prevention — highly active antiretroviral therapy (HAART), the treatment of latent TB infection and a reduction in HIV transmission.

They found that even where the prevalence of HIV infection is high, finding the curing active TB is the most effective way to minimise the number of TB cases and deaths over a 10-year period. HAART is apparently effective only with very high levels of coverage and compliance. The treatment of latent TB is relatively ineffective. However, in the long term, reducing the transmission of HIV is relatively effective in preventing TB.

The authors conclude that in countries where the spread of HIV has led to significant increases in the incidence of TB, the most effective TB control programmes should maintain a strong emphasis on the treatment of active TB. Prevention is also important, but not a substitute for active case finding.

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Currie SM, *et al. AIDS* 2003; **17**: 2501-2508.

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SINGLE SUTURE

MALARIA VACCINES

Malaria kills 2 - 3 million people each year. Where are we in the search for a much-needed vaccine? It does seem technically feasible to develop a malaria vaccine and the rate of clinical assessment of candidate malaria vaccines is increasing, with 11 groups doing such research. However, a practical limitation is the lack of worldwide good manufacturing practice manufacturing facilities for recombinant viral vaccines, for example. Costs are also important and need to be considered before planning large efficacy trials. Informed consent is another complex issue. In rural Africa, community consent is often more important than individual consent, while low literacy levels complicate matters further. However, increases in funding, if they continue, may mean that we will have a malaria vaccine candidate with sustained efficacy in infants, young children or both.

Moorthy VS, *et al. Lancet* 2004; **363**: 150-156.