Correspondance

The best things in life are free … at least, some of them are

It's good news that *CMAJ* was in fifth place among the world's general medical journals in 1999 (after the *New England Journal of Medicine*, *JAMA*, *The Lancet* and *BMJ*), when ranked according to impact factors provided by the Institute for Scientific Information.[1]

There's additional good news. Of these 5 journals, only *BMJ* and *CMAJ* are, at present, freely and publicly available online. Data for October 2000 from the Web site of Free Medical Journals.com (www.freemedicaljournals.com) indicate that, of the free general medical journals, *CMAJ* is in second place when ranked according to impact factor. It will be very interesting to see whether the impact factors of highly ranked free medical journals increase over the next few years, in comparison with the impact factors of journals that are not free.

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Reference

1. *CMAJ*'s impact factor improves. *CMAJ* 2000; 163(9):1182.

Correction

Owing to an editorial error, the recommendations of the updated clinical practice guideline concerning adjuvant systemic therapy for node-negative breast cancer were not included with the summary of the guideline published in the Jan. 23, 2001, issue of *CMAJ*.[1] The recommendations appear in Table 1.

Reference

1. Levine M, for the Steering Committee on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer. Clinical practice guidelines for the care and treatment of breast cancer: adjuvant systemic therapy for node-negative breast cancer (summary of the 2001 update). *CMAJ* 2001;164(2):213.

Table 1: Recommendations from the clinical practice guideline for the care and treatment of breast cancer: 7. Adjuvant systemic therapy for women with node-negative breast cancer

- Before deciding whether to use adjuvant systemic therapy, the prognosis without adjuvant therapy should be estimated.
- A patient's risk for recurrence can be categorized as low, intermediate or high on the basis of tumour size, histologic or nuclear grade, estrogen receptor (ER) status, and lymphatic and vascular invasion (LVI).
- For each individual, the choice of adjuvant therapy must take into account the potential benefits and possible side effects. These must be fully explained to each patient.
- Pre- and postmenopausal women who are at *low risk* of recurrence can be advised not to have adjuvant systemic treatment. Women who are at low risk, if seeking treatment, may consider tamoxifen.
- Women at *high risk* should be advised to have adjuvant systemic therapy. Chemotherapy should be recommended for all premenopausal women (less than 50 years of age) and for postmenopausal women (50 years of age or older) with ER-negative tumours. Tamoxifen should be recommended as first choice for postmenopausal women with ER-positive tumours. For this last group of patients, further benefit is obtained from the addition of chemotherapy to tamoxifen, but the expected incremental toxicity must also be considered. Whether tamoxifen following chemotherapy should be routinely recommended for premenopausal women with ER-positive tumours is unclear.
- For women at *intermediate risk* with ER-positive tumours, tamoxifen should normally be the first choice. For those who decline tamoxifen, chemotherapy may be considered.
- For most patients over 70 years of age who are at high risk, tamoxifen is recommended for ER-positive tumours. For those with ER-negative disease who are in robust good health, chemotherapy is a valid option.
- There are 2 recommended chemotherapy regimens: (1) 6 cycles of cyclophosphamide, methotrexate and 5-fluorouracil (CMF); (2) 4 cycles of Adriamycin and cyclophosphamide (AC). More intensive combinations such as CEF (cyclophosphamide, epirubicin and 5-fluorouracil) and AC-Taxol have not yet been evaluated in node-negative disease.
- Tamoxifen should normally be administered at a dose of 20 mg daily for 5 years.
- Patients should be encouraged to participate in therapeutic trials whenever possible.

Submitting letters

Letters may be submitted via our Web site or by mail, courier, email (pubs@cma.ca) or fax. They should be no more than 300 words long and must be signed by all authors. A signed copy of letters submitted by email must be sent subsequently to *CMAJ* by fax or regular mail. Letters written in response to an article published in *CMAJ* must be submitted within 2 months of the article's publication date. *CMAJ* corresponds only with the authors of accepted letters. Letters are subject to editing and abridgement.

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