

backs of liquid-based cytology notwithstanding, this technique does represent an improvement over conventional smear techniques. The few studies that satisfy today's stringent criteria for quality of evidence have found liquid-based cytology to be significantly more sensitive than the conventional Pap test.^{2,5}

The evidence for the effectiveness of the Pap test as a cancer control measure was obtained in an era before the randomized controlled trial paradigm became widespread. Newer techniques are being judged by criteria that are far more stringent than the ones used to place the Pap test on its current pedestal. Well-designed studies with suitable end points are expensive and take many years. Privileged observers of the cervical cancer screening scene, such as Ellison, should take this into account before prematurely repudiating new methods.

We agree that it is unfortunate that reliance on new technologies may limit the practice of cervical cancer screening to a few commercial interests. However, as these technologies gain ground, competition is likely to ensue and the present monopolies will disappear.

Eduardo L. Franco

Departments of Oncology and
Epidemiology
McGill University
Montreal, Que.

Eliane Duarte-Franco

Department of Oncology
McGill University
Montreal, Que.

Alex Ferenczy

Department of Pathology
McGill University
Montreal, Que.

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Support groups for people carrying a *BRCA* mutation

The study by Lisa Di Prospero and colleagues on the psychosocial impact of genetic testing for *BRCA1* and *BRCA2* mutations is important and one of the first to explore the perceptions of tested women in Canada.¹ We believe, however, that it may be premature to state that the "organization of support groups for people found to have the gene mutation should be a priority" for clinical programs providing testing.

We are currently conducting a prospective study describing a range of outcomes of *BRCA1* and *BRCA2* testing among Quebecers during pretest genetic counselling and 1 month, 1 year and 3 years after result disclosure. Nearly half the projected consecutive series of 900 participants have been recruited to date. Participation exceeds 85%. Our data indicate relatively low interest in support groups in this population. Of the 91 subjects questioned to date at 1 year after they learned their test result, 27% of the people with a *BRCA* mutation (10/37), 20% of people with inconclusive results (2/10) and 14% of people without a *BRCA* mutation (6/44) expressed moderate or great interest in having access to support groups. Recent research among breast cancer patients suggests that peer discussion groups may be harmful to women who already have high levels of support.² This is an important point, as 75% of the participants in the study by Di Prospero and colleagues felt that support from family and friends was meeting their needs.

We believe that psychosocial interventions for people undergoing genetic testing for breast cancer susceptibility are justified, given the current consensus that all people should have access to psychosocial care. However, given that our present state of knowledge is based on data from small numbers of tested

people, more research may be needed before a clear-cut recommendation can be made concerning support groups.

Michel Dorval

Assistant Professor
Faculty of Pharmacy
Laval University
Quebec City, Que.

Elizabeth Maunsell

Professor
Department of Social and Preventive
Medicine
Laval University
Quebec City, Que.

Michel J. Dugas

Assistant Professor
Department of Psychology
Concordia University
Montreal, Que.

Jacques Simard

Professor
Department of Anatomy and Physiology
Laval University
Quebec City, Que.

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[The authors respond:]

We thank Michel Dorval and colleagues for their interest in our study¹ and agree with their statement that the majority of people carrying a *BRCA1* or *BRCA2* mutation do not need support groups. By no means were we trying to suggest that all people carrying one of these mutations should be encouraged to join support groups. Genetic testing populations are heterogeneous and one would not expect a single intervention to address the psychosocial needs of all people carrying a *BRCA* mutation.

What we did say was that "a significant minority of [people carrying a *BRCA* mutation] desire such a service." This "significant minority" was 9 of the 24 patients who participated in our study (38%); this is not statistically sig-

nificantly different from the 27% of people carrying a *BRCA* mutation in the survey by Dorval and colleagues who expressed moderate or great interest in support groups ($p = 0.19$, t -test for 2 proportions from independent groups). In another recently published needs assessment of Canadians carrying a *BRCA* mutation, 68% of women surveyed stated an interest in support groups and 34% said they would participate in a group if given the opportunity.²

Because the group support study by Helgeson and colleagues consisted of women receiving chemotherapy and "harm" was only noted for the physical and not the mental health parameters measured, it is not clear that their findings are relevant to healthy people carrying a *BRCA* mutation.³ Nevertheless, we acknowledge that there is potential for peer support groups to do harm.

We are currently developing a group therapy model for people carrying a *BRCA* mutation that involves careful attention to the content as well as the process of delivery, and in-depth training of the group leaders. Each group includes women who have and have not had cancer. Feedback from the participants has been almost universally positive.

Lisa S. Di Prospero

(formerly) Division of Medical Oncology
Toronto–Sunnybrook Regional Cancer
Centre
Toronto, Ont.

Maureen Seminsky

Division of Medical Oncology
Toronto–Sunnybrook Regional Cancer
Centre
Toronto, Ont.

Joanne Honeyford

Department of Clinical Genetics
North York General Hospital
Toronto, Ont.

Brian Doan

Department of Psychology
Toronto–Sunnybrook Regional Cancer
Centre
Toronto, Ont.

Edmee Franssen

Department of Clinical Trials
and Epidemiology
Toronto–Sunnybrook Regional Cancer
Centre
Toronto, Ont.

Wendy Meschino

Department of Clinical Genetics
North York General Hospital
Toronto, Ont.

Pamela Chart

Head (retired)
Preventive Oncology
Toronto–Sunnybrook Regional Cancer
Centre
Toronto, Ont.

Ellen Warner

Division of Medical Oncology
Toronto–Sunnybrook Regional Cancer
Centre
Toronto, Ont.

Mary Jane Esplen

Head
Psychosocial and Psychotherapy Research
in Cancer Genetics
Mount Sinai Hospital
Toronto, Ont.

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Funding of global health research

As I catch up on my reading of *CMAJ* while in La Paz, Bolivia, where I am a volunteer for the Canadian Society for International Health, it seems important to endorse comments made by Victor Neufeld and colleagues regarding funding by the Canadian Institutes of Health Research.¹ They reminded us of the 1990 recommendation of the Commission on Health Research for Development that "at least 5% of international aid for the health sector should be earmarked for research and strengthening of research capacity" in countries receiving aid from industrialized countries. Earmarking aid in this way is not only consistent with Canadian values, it is also in our self-interest to do so.

Multidrug resistance is a good example of a problem that does not recognize borders. But self-interest can be economic as well. Canada has spent and continues to spend millions of dollars to decrease mortality in children owing to diarrhea, yet recently it has been revealed that the overall incidence of diarrhea in countries receiving aid does not appear to have diminished.² Although there may be many reasons why the root of this health problem is not being affected, it is likely that underfunding of researchers in developing countries is a major factor. Experts in countries where childhood mortality owing to diarrhea is widespread are much more likely to design studies that will provide the necessary insights in this area than any of us in the First World, but they will probably need financial and other forms of collaboration.

Does it not make more sense to fund research that will lead to prevention than to pay to manage an ongoing problem?

Bernadette Singer

Faculty Epidemiologist
Public Health Research, Education
and Development program
Middlesex–London Health Unit
London, Ont.

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[One of the authors responds:]

The endorsement by Bernadette Singer of our recommendations is welcome. Since we submitted our commentary,¹ there have been several encouraging developments that demonstrate increasing awareness of, involvement in, and funding of global health research by Canadians.

Four federal agencies (the Canadian International Development Agency, the Canadian Institutes for Health Research, Health Canada and the International Development Research Centre) have signed a framework agreement to pro-