

Open letter to Lamberto Andreotti, Chief Executive Officer, Bristol-Myers Squibb

We, the UNITAID board members representing non-governmental organisations (NGOs) and communities affected by HIV/AIDS, tuberculosis, and malaria, are writing to you to express our deep concern that Bristol-Myers Squibb (BMS) is to close a factory in France that manufactures a second-line antiretroviral medicine for children with HIV/AIDS who weigh less than 10 kg: buffered didanosine in the 25 mg formulation.

Closing this factory means that 4000–7000 babies currently enrolled in treatment plans in developing countries through UNITAID could be left without the medicines they need. Didanosine is the last therapeutic option for these babies and without it they could die. We understand that closure of the plant will take place in June of this year, with no plans for resumption of production before April, 2011, at the earliest, when a new plant is due to open. Therefore there is likely to be a shortage of about 15000 packs of didanosine 25 mg across all UNITAID beneficiary countries between now and when production is expected to resume in April, 2011.

Currently, there is no alternative generic product that has been assessed by WHO and prequalified for use by UN agencies. We urge you, as the Chief Executive Officer of BMS, a company that prides itself on its high standards of corporate responsibility, to respond urgently to our concerns, outlining the steps you will take to avoid any treatment interruption. We would also like your confirmation that a BMS plant will resume production of this vital medicine in 2011.

Supporting the NGOs and communities delegations: Action for Southern Africa; Act Up, Lusaka, Zambia; Africare; Agency for Community Care and Development; Asian Harm Reduction Network; Centre for Health Policy and Innovation; Coalition of Zambian Women Living with HIV/AIDS (COZWHA+); Coalition PLUS; Community Initiative for Tuberculosis, HIV/AIDS

& Malaria (CITAM+), Zambia; Consumer Information Network (CIN), Kenya; Ecumenical Pharmaceutical Network; Global AIDS Alliance; Health Action International (HAI) Africa; Health Access Network (HAN), Ghana; Health GAP (Global Access Project); IHA's Medical and Social Foundation, India; Love Life Society; Médecins Sans Frontières; National Community of Women Living with HIV/AIDS in Uganda (NACWOLA); Network of Maharashtra People with HIV (NMP+); Positive Generation, Cameroon; Stop AIDS Campaign, UK; TB ACTION Group, Kenya; The Touch of Hope Foundation; and Universities Allied for Essential Medicines.

**Mohga Kamal-Yanni, Kim Nichols, Esther Tallah, Nelson Otswana*
mkamalyanni@oxfam.org.uk

Oxfam GB, Oxford OX4 2JY, UK (MK-Y); African Services Committee, New York, NY, USA (KN); Cameroon Coalition Against Malaria, Yaounde, Cameroon (ET); and National Empowerment Network of People Living with HIV/AIDS in Kenya, Nairobi, Kenya (NO)

MRI for breast conservation surgery

In the COMICE trial (Feb 13, p 563),¹ Lindsay Turnbull and colleagues found that preoperative breast MRI did not reduce the rate of re-excisions in women with primary breast cancer who were scheduled for wide local excision. The generalisability of these results is, mostly owing to very low inclusion in many centres, highly questionable. We showed that, in centres with experience, the rate of re-excisions in lobular cancers can be substantially reduced.² Nevertheless, Turnbull and colleagues conclude "that MRI might not be necessary in this population of patients in terms of reduction of reoperation rates".

Irrespective of the validity, it is tempting to interpret their statement as "preoperative MRI is not indicated in patients with newly detected breast cancer". However, the current indication for preoperative MRI, as endorsed by various organisations (eg, the American College of Radiology³ and the European Society of Breast Imaging), is not based on reduction of reoperation rates, but rather is a screening recommendation for the contralateral breast. Whereas residual disease in the ipsilateral breast can be effectively treated

with radiotherapy, tumours in the contralateral breast are basically left untreated when undetected.

MRI screening of the contralateral breast has, at about 4%, the highest cancer yield of any type of breast cancer screening⁴ (2% contralateral carcinomas as reported in Turnbull and colleagues' study is exceptionally low). Early detection of second cancers has been shown to result in increased survival (between 27% and 47%).⁵ Although that study did not assess preoperative MRI, its conclusions are unambiguous: second cancers should be detected at the earliest stage possible, which is effectively achieved by MRI. Consequently, because the effect of preoperative breast MRI on the ipsilateral breast is not detrimental, the indication is unchanged.

We declare that we have no conflicts of interest.

**R M Mann, C Boetes*
r.mann@rad.umcn.nl

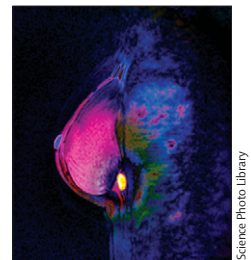
Radboud University Nijmegen Medical Center, PO Box 9101, 6500 HB Nijmegen, Netherlands (RMM); and University Medical Centre Maastricht, Maastricht, Netherlands (CB)

- 1 Turnbull L, Brown S, Harvey I, et al. Comparative effectiveness of MRI in breast cancer (COMICE) trial: a randomised controlled trial. *Lancet* 2010; **375**: 563–71.
- 2 Mann RM, Loo CE, Wobbes T, et al. The impact of preoperative breast MRI on the re-excision rate in invasive lobular carcinoma of the breast. *Breast Cancer Res Treat* 2010; **119**: 415–22.
- 3 American College of Radiology. ACR practice guideline for the performance of contrast-enhanced magnetic resonance imaging (MRI) of the breast. http://www.acr.org/SecondaryMainMenuCategories/quality_safety/guidelines/breast/mri_breast.aspx (accessed June 2, 2010).
- 4 Brennan ME, Houssami N, Lord S, et al. Magnetic resonance imaging screening of the contralateral breast in women with newly diagnosed breast cancer: systematic review and meta-analysis of incremental cancer detection and impact on surgical management. *J Clin Oncol* 2009; **27**: 5640–49.
- 5 Houssami N, Ciatto S, Martinelli F, Bonardi R, Duffy SW. Early detection of second breast cancers improves prognosis in breast cancer survivors. *Ann Oncol* 2009; **20**: 1505–10.

In the report by Lindsay Turnbull and colleagues,¹ addition of MRI to the preoperative assessment of small breast cancers failed to reduce the reoperation rate, which reached around 19%. Among the tumours excised



Published Online
June 7, 2010
DOI:10.1016/S0140-6736(10)60940-3



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