Induced abortion and breast cancer

Sir

This letter to the editor concerns the reply by C.M. Bräuner and J. Attermann to comments by J. Brind and P. Carroll published on-line in September 2013 (1), following previous correspondence in an earlier issue (2) regarding the article of Bräuner and co-workers (3).

The reply by C.M. Bräuner and J. Attermann to our letters is interesting and also puzzling! They maintain the reason for not having access to the Danish national register that holds the abortion records was “not a lack of political will”. If it was for the reason of “simply a lack of time and resources” and access to the register is possible for a future study, one hopes this will indeed be a priority when future research on breast cancer is being planned in Denmark. The authors were “reluctant” to include in situ carcinomas because this “might have introduced selection bias” as “reporting of this type of cancer probably is incomplete”. It seems that the in situ carcinomas show up quite well on the X-rays in screening but are not otherwise easily detectable. So there would hardly be much reason to expect selection bias. Reporting of these carcinomas in situ to national cancer registries is certainly desirable and is usual practice in the UK and other European countries with effective national registration of newly diagnosed cancers. For lack of relevant Danish data in my 2007 paper (4), there were no forecasts of in situ carcinomas in Denmark and of course this accords with “In situ carcinomas are not … included in the Danish Cancer Registry. Therefore it would be difficult to obtain these data”. To calculate the in situ carcinomas anticipated for six other countries, I had simply assumed that the ratio of in situ to malignant carcinomas discovered in the screened age groups, as reported by their cancer registries, would remain fixed. But now of course the new digital screening machines are finding more in situ carcinomas and in some countries like the UK the age range for cancer screening has been extended upwards. The ratio of in situ to malignant disease can now exceed 12% in age groups screened. It would be a good idea if the Danish Cancer Registry did count and report the in situ carcinomas that have now become a larger part of the overall breast cancer picture.

It was surprising that this study found no association between induced abortion and breast cancer among parous older women. The new Chinese study by Huang et al. (5), which is a meta-analysis of 36 Chinese small sample (34 case-control and 2 cohort) studies finds “that induced abortion is significantly associated with an increased risk of breast cancer among Chinese females, and the risk of IA increases as the number of IA increases.” This adds to the evidence for recognition of induced abortion as a risk factor in breast cancer, which remains still unacknowledged by most leading epidemiologists. When breast cancer incidence is so high it is a reason for concern that such a major public health issue as breast cancer aetiology continues to be unresolved. When there are as many as 50,000 new cases of breast cancer reported here each year, the British breast cancer epidemiologists explain this only in vague terms. The remarkable social gradient of female breast cancer, whereby women in the higher socio-economic groups have more breast cancer and less of the other cancers, is well known and widely reported in many countries but remains unexplained (4). It is to be hoped that the authorities will allow access to national registers that include induced abortion records in countries like Denmark and Finland where there is the potential to definitively resolve the issue of breast cancer risks post abortion. Meanwhile, this substantial study by C.M. Bräuner et al. can point the way to how this might be approached.

Patrick Carroll*

Pension and Population Research Institute (PAPRI), London, UK

*Corresponding Author:
Patrick Carroll

E-mail: papriresearch@btconnect.com

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References


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