

CORRESPONDENCE

REASON TO SCREEN FOR PROSTATE CANCER BASED ON SELECTIVE REFERENCING

To the Editor:

In their article, Ransohoff et al. describe why prostate cancer screening is so common, even though the evidence supporting screening is uncertain (1). We agree completely with the points made and with their conclusions. The authors overlook one important factor, however, and involuntarily demonstrate this omission in their article: the selective use of references.

They refer to the landmark study by Holmberg et al. (2), mentioning that “for persons with cancers discovered by means other than screening, surgical therapy may reduce prostate cancer mortality compared with watchful waiting” (1). In doing so, they omit the important remarks by Holmberg et al. regarding the probable lower effect of radical treatment in prostate cancers detected by screening owing to the lower baseline risk of death from prostate cancer (2). Moreover, they do not cite the most important conclusion—in our view—of the Holmberg study, which was “surgical therapy does not reduce overall mortality compared with watchful waiting” (2).

Although Ransohoff et al.’s citation of Holmberg et al. is correct word for word, an optimistic interpretation of their data is given, thus formulating a view on treatment of localized prostate cancer that is too optimistic. For clinicians, this might be another positive reason to screen their patients for prostate cancer. We believe that this is not sufficiently founded.

Readers may easily overlook the major nuances of a referenced article. Therefore, we think that it is important for authors and editors to guar-

antee the accuracy of objective information from cited articles.

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1. Ransohoff DF, McNaughton Collins M, Fowler FJ Jr. Why is prostate cancer screening so common when the evidence is so uncertain? A system without negative feedback. *Am J Med.* 2002;113:663–667.
2. Holmberg L, Bill-Axelson A, Helgesen F, et al. A randomized trial comparing radical prostatectomy with watchful waiting in early prostate cancer. *N Engl J Med.* 2002;347:781–789.

The Reply:

We agree that the positive results of the Holmberg trial (1) do not apply to persons with screening-detected prostate cancer, for whom therapy may have a lower effect or even none at all. We also agree that the lack of an overall mortality effect is an important feature of the trial’s results. We did not elaborate on the results of therapy in part to emphasize our main point, which is totally independent of whether one believes therapy has any benefit for screening-detected prostate cancer—i.e., multiple forces in the decision-making environment push toward aggressive decisions for both screening and therapy and toward a perception of benefit, independent of whether there is any actual benefit. We agree with the writers and others that there are no data to demonstrate the benefit of prostate cancer screening among asymptomatic persons (2,3).

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1. Holmberg L, Bill-Axelson A, Helgesen F, et al., and the Scandinavian Prostatic Cancer Group Study Number 4. A randomized trial comparing radical prostatectomy with watchful waiting in early prostate cancer. *N Engl J Med.* 2002;347:781–789.
2. Screening for prostate cancer: recommendation and rationale. *Ann Intern Med.* 2002;137:915–916.
3. Harris R, Lohr KN. Screening for prostate cancer: an update of the evidence for the U.S. Preventive Services Task Force. *Ann Intern Med.* 2002;137:917–929.

SUBACUTE MOTOR WEAKNESS AND LEFT RENAL MASS

To the Editor:

A 65-year-old white woman presented with facial palsy and progressive weakness of both arms and legs. She had no previous history of fever, chills, recent infections, allergies, recent immunization, exposure to neurotoxic chemicals, and use of tobacco, illicit drugs, and alcohol. Her family history was unremarkable. Her temperature was 36.6°C, pulse was 105 beats per minute, and respiration rate was 25 breaths per minute. Blood pressure was 110/90 mm Hg. Hematologic laboratory values were normal. The physical examination showed no abnormalities. The patient was alert. Sensitivity to light, touch, and pinprick was normal, as was coordination. Neurologic examination revealed bilateral distal weakness on dorsal flexion of the feet, tingling paresthesias in the hands, and loss of tendon reflexes in both arms and legs. Muscle bulk, tone, and strength were normal. Neurophysiologic findings suggested a polyneuropathy of recent onset. Examination of the right median and tibial nerves showed reduced motor nerve conduction velocities in the upper and lower limbs. F waves and H reflex recorded after stimulation of tibial nerves were absent. Repetitive stimulation studies of the intrinsic hand muscles before and after exercise