A NECESSARY STATEMENT

To the Editor:

Reading the excellent review presented by Yaron Niv, "Capsule endoscopy: No longer limited to the small bowel," in your March issue (2010; vol 12: p. 178), I searched the article for the necessary declaration regarding "conflicts of interest" as required by the International Committee of Medical Journal Editors (ICMJE) to whose requirements *IMAJ* is obligated. I did not find such a declaration. I quote: "As in the case of authors, silence on the part of reviewers concerning potential conflicts may mean either that conflicts exist and the reviewer has failed to disclose them or conflicts do not exist. Reviewers must therefore also be asked to state explicitly whether conflicts do or do not exist. Reviewers must not use knowledge of the work, before its publication, to further their own interests."

I suggest to the editors that they adapt the recommendations of the above mentioned committee, to the benefit of all concerned.

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To the Editor:

The comment of Dr. Nahum Werbin is important, since disclosure of any conflict of interest should be an integral part of any scientific paper. As a member of the Editorial Board of IMAJ, I support the notion of adding such a declaration for every paper accepted for publication.

Relating to the specific review that was chosen by Dr. Werbin to represent all the papers in IMAJ, I have two comments: I am glad that Dr. Werbin found it "excellent," and I have no conflicts of interest.

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Editor's note:

Readers are referred to our Instructions for Authors, which clearly stipulates the requirement for such a declaration.

CANCER SCREENING

To the Editor:

After reading the "First Report of Screening an Asymptomatic Population for Cancer," by Drs. Ben Boursi and associates (*IMAJ* 2010; 12: 21-5), I was left uncertain regarding some of the presented methods and findings.

First, Table 1 is entitled "Screening and surveillance recommendations" without stating the source of these recommendations. Professional organizations differ in their recommendations. There is undisputed evidence supporting early detection of breast, colorectal and cervical cancers. However, to the best of my knowledge, there is insufficient evidence to recommend for or against routine screening for the early detection of cutaneous melanoma, basal cell cancer, or squamous cell skin cancer, oral cancer, ovarian cancer, cancer of the prostate, testicular cancer and thyroid cancer.

Second, there seems to be an inconsistency between the caption of Figure 1 and the text. The figure says that colonoscopy, prostate-specific antigen, dermatologic examination, mammography, trans-vaginal ultrasound and Pap smear were "non-routine tests that were administered only when indicated." However, the text states that "All subjects had a thorough dermatologic examination; all men had a testicular exam; and all women had a trans-vaginal ultrasound and Pap smear…. The screening tests consisted of prostate-specific antigen for all men above the age of 40, colonoscopy for all men older than 40 and all women older than 50, mammography for all women over age 40." Therefore, it is not clear whether colonoscopy, prostate-specific antigen, dermatologic examination, mammography, trans-vaginal ultrasound and Pap smear were administered to all patients of the appropriate gender, or only when indicated.

Third, the authors state both in the text and in a footnote of Table 1 that "A low dose CT [was] performed only after discussing its value with the patients. Not all authorities recommend screening for lung cancer." This statement conveys the impression that all authorities do recommend screening for all of the remaining cancers, and this was further reinforced by the authors' statement that "There is little controversy about the potential importance of preventive measures in terms of lifestyle choices and early detection of cancer in reducing morbidity and mortality from cancer." I agree with the authors about the importance of lifestyle choices. However, I am not aware of any definitive evidence that early detections of cancer of the ovaries, uterus, skin, oral cavity, prostate, testicles and thyroid reduce mortality.

Fourth, the authors do not mention the frequency of false-positive findings. Table 2 indicates that benign or malignant tumors were detected in a total of 25 patients. Table 3 indicates that as many as 44 patients tested positive on any of the screening examinations. This suggests that 19 patients had a false-positive test result. How was malignancy excluded in these 19 patients? How many patients had additional investigations for false-positive test results? For example, Table 3 states that three patients had a positive test for prostate-specific antigen (PSA). Table 2 indicates that there were only two cases of prostate cancer. In other words, one patient had a false-positive PSA test. How was prostate cancer ruled out in this patient? By multiple biopsies? A second example: Table 2 indicates that there were no cases of lung cancer. Table 3 states that one patient tested positive on low dose CT. In other words, this patient had a false-positive low dose CT. How was lung cancer ruled out in this patient? By bronchoscopy? By thoracotomy?

Fifth, the report left me uncertain whether it describes a state-of-the-art practice or a research project. If it proposes a practice innovation, I miss its cost-effectiveness (how much money was invested in order to detect a malignant tumor?) and its evidence base. If this was indeed a research project, as suggested by the fact that the study was approved by the Tel Aviv Sourasky Medical Center Helsinki Committee, then I miss a conflict of interests statement: who funded the study? A grant donation? The hospital? The patient's health insurance? The patients themselves? Were the patients given any information in addition to the statement that not all authorities recommend screening for lung cancer?

Finally, I concur with the authors' conclusion that the benefit of early detection of cancer should be further studied. However, I am uncertain whether their report provides any evidence for such benefit, or for the efficacy of an Integrated Cancer Prevention Center devoted to early detection of cancer in apparently healthy adults.

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To the Editor:

We appreciate the comments of Prof. Benbassat and wish to provide the following clarifications and explanations.

1. Our study population comprised subjects aged 25–77, thus not all subjects had undergone colonoscopy, PSA or mammography. All subjects were first screened for dermatologic lesions by the physician at the center (N.A.), and in the event of a suspected finding they were sent to a dermatologist/plastic surgeon.
2. The author misunderstood the tables. According to Table 3, 29 lesions were detected among the subjects. Fifteen of those lesions were detected in average-risk subjects. Four lesions were not included in Table 2 since they were lesions with no malignant potential. Prof. Benbassat is correct with regard to the title of Table 3, which should have been "suspected neoplastic lesions."
3. Prostate cancer was ruled out by multiple biopsies. Regarding the patient with the lung lesion, the treating physicians decided to follow the CT finding and a repeated exam did not show a change in the lesion.
4. The current study is a pilot study which reports our initial experience with the first 300 subjects who underwent simultaneous screening for cancer. We needed the Helsinki Committee's approval for the genetics part of the study. The routine tests were partially paid by the patients who could afford it, or for free if they could not.
5. Time will tell. This is the first integrated cancer prevention center worldwide. We believe that from our initial observations better and more effective screening programs will be developed.

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Erratum
In the article "Clinical manifestations in Israeli cystinuria patients and molecular assessment of carrier rates in Libyan Jewish controls" published in *IMAJ* [2003; 5(6): 439-42], a mistake occurred in the spelling of one of the authors' name. It should be Kreiss Y and not Kreiss I as printed.