rescreening rates. The authors acknowledge that rescreening rates varied between the initial screening round and subsequent screening rounds but failed to include this in a multivariate analysis.

Reported rescreening rates within the analysis were 62.4% for all women screened in the initial round and 72.5% for women screened in a second or subsequent round.

When the effect of a false-positive result was reported by screening round, the absolute difference was much lower for both first screens (1.5 percentage points) and subsequent screens (1.0 percentage points).

The data presented showed that 37% of women who had a false-positive screening result were undergoing their first screening mammogram through the BSWA program and that only 18% of women with a true-negative result were participating for the first time. There are many reasons why false-positive results should be minimised within any screening program; however, because of the overrepresentation of women undergoing a first screen in the false-positive group, these data overstate the true effect of false positives on the rescreening rate.

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1 Sim MJH, Siva SP, Ramli IS, et al. Effect of false-positive screening mammograms on rescreening in Western Australia. *Med J Aust* 2012; 196: 693-695. ❑

Drug treatment for melanoma: progress, but who pays?

To the Editor: The recent editorial by Kefford[1] fails to mention that (i) the 5-year survival for malignant melanoma is excellent at 89% for males and 91% for females; (ii) treatment with the new melanoma drug ipilimumab for the 1279 people who died from melanoma in 2007 would cost the Australian Government $156 million based on the quoted drug cost of $120 000 for a course of four injections; and (iii) the increase in survival is only minimal with ipilimumab (median survival, 10.1 months v 6.4 months for placebo).[2]

The enthusiasm about the "practice-changing discovery of drug therapy against brain metastases" ignores the publication from the Sydney Melanoma Unit in 2004[3] showing that after surgery and postoperative radiotherapy, the median survival was 8.9 months (with a range of up to 17 years) — an option that would cost far less than treatment with ipilimumab.

In 1977, when the specialty of medical oncology was first established in Australia, drug treatment was promoted as being "the cure for cancer". However, time has shown this belief to be incorrect and has instead confirmed that drug treatment is the most costly and least effective of the cancer treatment modalities.

The Pharmaceutical Benefits Scheme cost of chemotherapy for drugs alone has risen by over 400%, from $302 million for the 2001–02 financial year to $1225 million for 2010–11[4] — an average annual increase of $92 million.

Clearly, the request by Kefford for funding is not appropriate for what is essentially a minimally effective palliative treatment. If such money were available, it would be far better spent addressing the current lack of palliative care services in Australia, to ensure that those whom we cannot cure, despite new drugs, can die with comfort and dignity.

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1 Kefford RF. Drug treatment for melanoma: progress, but who pays? *Med J Aust* 2012; 197: 198-199.

2 Hodi FS, O'Day SJ, McDermott DF, et al. Improved survival with ipilimumab in patients with metastatic melanoma. *N Engl J Med* 2010; 363: 711-723.

3 Fife KM, Colman MH, Stevens GN, et al. Determinants of outcome in melanoma patients with cerebral metastases. *J Clin Oncol* 2004; 22: 1293-1300.

4 Australian Government Department of Health and Ageing. Pharmaceutical Benefits Scheme. PBS expenditure and prescriptions. Table 5: ATC main group comparison (incl drs bag), years ending Jun 2003 to Jun 2011. http://www.health.gov.au/internet/main/publishing.nsf/Content/pbs_expenditure_prescriptions-copy1 (accessed Aug 2012). ❑

> "drug treatment is the most costly and least effective of the cancer treatment modalities"
>
> Morgan

> "The greatest opportunity to improve outcomes will come . . . from learning how to deliver existing effective therapies"
>
> Fullerton

To the Editor: Kefford's contention that making cancer drugs affordable requires coherent policy and cannot be left to market forces[1] is correct.

Two new drugs, ipilimumab and vemurafenib, are now approved by the United States Food and Drug Administration and the Australian Therapeutic Goods Administration for use in metastatic melanoma. However, their efficacy in a minority of patients is low. The cost of this palliative treatment is eye-wateringly high. Reimbursement for ipilimumab has been refused in Australia and the United Kingdom.

The greatest opportunity to improve outcomes will come not from discovering new treatments, but from learning how to deliver existing effective therapies.[2]

An existing effective therapy in quality end-of-life care is palliative service provision. Arguably less glamorous, it improves quality of life[3] and can also prolong life compared with standard treatments.[4]

All dying Australians should have access to quality palliative care to prevent unnecessary suffering.[5]

Resources in palliative treatments, including money spent on expensive, specifically targeted oncological therapies, could be better and more equitably spent on more generic palliative care services for all Australians.

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3 Bruera E, Yennurajalingam S. Palliative care in advanced cancer patients: how and when? *Oncologist* 2012; 17: 267-73.

4 Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med* 2010; 363: 733-742.

5 Palliative Care Australia. National Palliative Care Consensus Statement: a call to action. Canberra: PCA, 2011. http://www.palliativecare.org.au/Portals/46/PAL31612%20consensus%20statement_newer%20style%203%20(2).pdf (accessed Oct 2012). ❑

In reply: The letters of Morgan and Fullerton correctly emphasise the importance of palliative care in the management of patients with metastatic melanoma. They also draw attention to the immense cost of new drugs for melanoma, and their limited efficacy in life extension — something I also emphasised.[1] Much ignored in this debate is the rapid and dramatic improvement in *quality* of life experienced by nearly all melanoma patients on BRAF inhibitors,[2] an example of where medical oncology and palliative care should, and must, work hand in hand in optimising patient comfort. We strive toward this goal in our multidisciplinary teams. However, it is in the adjuvant setting that the new antimelanoma drugs are likely to show large improvements in survival and where reimbursement of drug costs will become an increasing challenge.

Morgan refers to the utility of adjuvant radiation therapy for cerebral metastases and quotes an uncontrolled retrospective series, from which, due to selection bias and other factors, only highly restricted conclusions can be made. Prospective randomised evidence for the benefit of adjuvant whole-brain radiation therapy awaits completion of an ongoing study by the Australia and New Zealand Melanoma Trials Group.

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1 Kefford RF. Drug treatment for melanoma: progress, but who pays? *Med J Aust* 2012; 197: 198-199.

2 Flaherty K, Puzanov J, Sosman J, et al. Phase I study of PLX4032: proof of concept for V600E BRAF mutation as a therapeutic target in human cancer. *J Clin Oncol* 2009; 27 (Suppl): abstract no. 9000. ❑

Subsidised use of methylnaltrexone in Australia for palliative care

To the Editor: Methylnaltrexone is a peripheral opioid antagonist registered for the treatment of opioid-induced constipation (OIC) on the basis of quality Phase III studies.[1] Monitoring uptake of a new medication such as methylnaltrexone after it has been listed on the Pharmaceutical Benefits Scheme (PBS) is crucial to understanding how such medications can be best used in routine clinical practice.

Compared with the whole population, higher numbers of palliative care patients receive laxatives. Many factors contribute to this, with opioid use remaining the most cited reason.[2] Australian epidemiological data estimate that more than 5000 people annually experience resistant OIC at the end of life.[3] In 2004, a palliative care section was added to the PBS for people with "active, progressive, far-advanced disease for whom the prognosis is limited and the focus of care is the quality of life".[4] The subsidised medications available under this section have increased from an initially modest number, and now include methylnaltrexone, listed in March 2010 for OIC that is unresponsive to other laxatives.

Following PBS listing of a drug, its use is monitored by the Drug Utilisation Sub-Committee (DUSC) of the Pharmaceutical Benefits Advisory Committee.[5] The DUSC conducted a review of all de-identified pharmacy claims for PBS-subsidised methylnaltrexone prescriptions from 1 March 2010 to 28 February 2011 (Methylnaltrexone 12 mg/0.6 mL [Relistor] utilisation report. Item 7.1, October 2011 agenda; unpublished report, available from DUSC@health.gov.au). Assuming that all initial prescriptions supplied corresponded to new patients, 261 patients were treated. Only 93 prescriptions for continuing medication were supplied. Uptake was far less than expected, with fewer initial and continuing prescriptions per patient contributing to this.

The review raises a number of issues. We cannot presently conclude whether these results represent:

- a multifactorial aetiology of constipation in this patient population, to which opioid use contributes relatively little;
- greater than expected effectiveness of other laxatives for treating OIC;
- patient preference; or
- differences between the efficacy of methylnaltrexone shown in clinical trials and its effectiveness in day-to-day clinical practice.

This illustrates that monitoring the actual uptake and continued use of new medications after their introduction is crucial, even when high-quality Phase III trials support their use.

> "Much ignored in this debate is the rapid and dramatic improvement in *quality* of life experienced by nearly all melanoma patients on BRAF inhibitors"
>
> Kefford

> "The annual number of new cases of liver cancer ... almost tripled between 1982 and 2007"
>
> MacLachlan et al

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Competing interests: Debra Rowett is a member of the Drug Utilisation Sub-Committee of the Pharmaceutical Benefits Advisory Committee.

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2 Twycross R, Sykes N, Mihalyo M, Wilcock A. Stimulant laxatives and opioid-induced constipation. *J Pain Symptom Manage* 2012; 43: 306-313.

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4 Australian Government Department of Health and Ageing. Pharmaceutical Benefits Scheme: pharmaceutical benefits for palliative care. http://www.pbs.gov.au/browse/palliative-care (accessed Oct 2012).

5 Australian Government Department of Health and Ageing. Pharmaceutical Benefits Advisory Committee. Membership of the Drug Utilisation Sub-Committee (DUSC) of the PBAC. http://www.health.gov.au/internet/main/publishing.nsf/content/health-pbs-general-listing-duscmember.htm (accessed Oct 2012). ❑

Liver cancer is the fastest increasing cause of cancer death in Australians

To the Editor: In September 2012, the Australian Institute of Health and Welfare (AIHW) released its report on cancer survival and prevalence in Australia from 1982 to 2010, incorporating incidence and mortality estimates for all malignancies reported to Australian cancer registries.[1] Cancer is a leading cause of morbidity and mortality in Australia, accounting for about 20% of the total disease burden and 30% of deaths.[2]

Liver cancer causes an increasing number of deaths in Australia every year, primarily related to the increasing prevalence of chronic viral hepatitis —