Dr Ulrich Abel

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Cancer Pioneers and Researchers

CHEMOTHERAPY: A DULL WEAPON

This article first appeared in Der Spiegel, 33/1990. English translation reprinted with permission from People Against Cancer, PO Box 10, Otho, Iowa.

For ten years, Ulrich Abel, 38, served the West German cancer doctors as a "number cruncher" (his own expression.) This graduate mathematician and PhD in epidemiology had been helping clinicians carry out their cancer investigations. His knowledge of method was in demand, and his relations with cancer experts were excellent.

This past spring, however, the Heidelberg biostatistician himself took up pen and brought out a small book with the title: Cytostatic Therapy of Advanced. Epithelial Tumors: A Critique (Hippocrates Verlag, Stuttgart. 112 pages. 28 marks.) Since that time Abel has become a Cain for many West German cancer specialists. Abel admits that in some cases he is no longer invited to participate in new research.

For a year this researcher, working in the Heidelberg/Mannheim Tumor Center, looked through all the literature that deals with chemotherapy (several thousand articles.) The findings of foreign chemotherapy researchers were studied by Abel as tenaciously as those of his native West German oncologists. In addition, he sent self-addressed envelopes to 350 cancer experts and cancer centers everywhere in the world in order to track down additional anti-tumor medication research which had not yet appeared in the cancer journals.

Abel expresses in a single word the outcome of his research: Appalling.

What was initially just a suspicion became a certainty when Abel had finally put the puzzle together: the weapon of chemotherapy has remained dull in the hands of cancer fighters. Even after decades of clinical application and therapeutic research, the cellular poisons (cytostatics) of cancer therapy in broad areas of cancer therapy have misfired.

USING DUMMY BULLETS

In the light of his year-long investigation, Abel concludes hat faith in the efficacy of chemotherapy is clearly a fixed dogma which cannot withstand the acid test of strict science.

The scientist's findings show that most kinds of cancer treatment, which are so productive of side effects, are disappointing for the patient, and for two reasons:

Chemotherapy is incapable of extending in any appreciable way the lives of patients suffering from the most common organic cancers.
Even the palliative effect of these medications, which supposedly improve the quality of life for the patient, rests on shaky scientific ground.

"A scientific wasteland," is how Abel describes the hemotherapy of advanced epithelial malignancies. These tumors include almost all organic cancers in which a potentially curative operation is no longer possible because the tumor has already metastasized, or has recurred after a course of treatment (relapse). These kinds of tumors constitute at least 80% of all deaths from cancer every year.

In advanced small-cell lung cancer it is possible that cellular poisons may extend life somewhat. But the benefit is very slight -- several months on the average. This is not true in breast cancer nor in stomach cancer, neither in intestinal, bladder, nor pancreatic cancer, when the case is advanced and metastasized.

According to Abel, the low efficacy of medicinal antitumor therapy is something of which neither the public nor the greater part of practicing physicians are particularly aware; chemotherapy cannot be recognized as appreciably prolonging the lives of patients [the first axiom of chemotherapy]. At least, there is no conclusive scientific evidence for it. Such evidence will become available when the survival rates of patients under chemotherapy can be systematically compared with those of untreated cancer patients within the framework of controlled clinical trials. But such a procedure has no chance of acceptance by ethics commissions made up of physicians.

"One cannot leave untreated a patient whose cancer is treatable with chemotherapy," state the West German experts, Dieter Karl Hossfeld [see next article, pg. 28] and Albrecht Pfleiderer, "just to find out if he might not survive just as long without therapy." Thus the benefits of chemotherapy are assumed axiomatically but are still not proven.

MISINTERPRETING OUTCOME

Also the fact that under chemotherapy the tumor mass shrinks or temporarily disappears completely (partial or complete remission) is, in Abel's view, not a good sign. For the remaining tumor cells which resist the effect of the medication sometimes grow much faster afterwards.

A connection between "response," meaning shrinking of the tumor tissue, and improved survival, which many physicians see as the justification for chemotherapy, cannot be documented in the literature. "Surprisingly often," Abel finds, the opposite occurs: patients in whom the medicine had no effect on the tumor survive longer.

According to Abel's findings, the second axiom of chemotherapy, the palliative effects of cytostatic medicines, also rests on scientifically shaky ground. Reliable studies, which might substantiate this belief for the majority of patients (exceptions are possible), "are not yet to be found." The least one can say is that older research in the 1970s reached the opposite conclusion: highly aggressive chemotherapy undertaken prematurely shortened the survival time as compared with patients in whom chemotherapy was first instituted only with the onset of pain and which was conducted less aggressively.

Abel observes that although the US FDA has yet to license a cancer remedy on the basis of improved quality of life (since no evidence in support of such a claim has yet been demonstrated), cancer patients are often bombarded with cellular poisons at a time when the tumor in the body is still painless.

Some of the reasons for the routine use of toxic assaults on the body, Abel maintains, have to do with a diffuse belief of physicians in the efficacy of their therapy. Above all, badly informed physicians are often urged by their frightened patients to commence with an aggressive therapy, causing many side effects at an early stage before the patient him/herself has complained of substantial pain.

Behind this willingness of clinicians to fire away there is often a compulsion to conduct research. Patients who are not suffering any pain are dragged at an early stage into chemotherapy because their treatment can be conducted as part of a clinical trial; but here, in Abel's view, it is hardly possible to give the patient an individualized therapy, oriented toward his own specific complaints.

Aggressive doses of cytostatics are an effort to legitimatize the theory of dosage. The higher the dose, the better the prospect that the tumor will shrink under the effect of the cellular poison. States Abel, "There is not yet any perceptible tendency in medicine to refrain from trials with high doses."

SHOOTOUT AT THE NOT OK CORRAL

The chemotherapy of advanced organic cancer is stuck in a blind alley out of which "an exit will be achieved only in small steps and not without some painful insights." Oncology, as the researcher puts it, has "up until now failed to provide an unobjectionable scientific basis for cytostatic therapy in its presently dominant form."

The thesis of the efficacy of cellular poisons and the overwhelming dominance of chemotherapeutic research which it has spawned, may, in Abel's judgement, be seen in the future as "one of the greatest missteps ever taken in oncology and the one with the most tragic consequences."

The change of direction which is "urgently needed" in the patient's interests run smack up against the various structures which have been erected in the meantime. About 90% of research capacity, in Abel's view, is tied in with ongoing chemotherapeutic investigations. The earnings of the pharmaceutical industry from anti-tumor medications amount to half a billion marks every year. Many cancer researchers get up to 1000 marks from the suppliers for each documented case they treat.

Alternative methods of treatment, such as immune therapy, scarcely make it into the running, since many physicians lack knowledge of them. Abel has ascertained, during his years of consulting work, that research proposals along these lines hardly get a hearing in new research plans.

So the other side has a hard time getting to the table. The advocates of immunotherapeutic approaches, or of certain other unconventional anticancer methods, are generally reluctant

to let their therapies be tested in comparison with chemotherapy in controlled clinical trials. [Innovative practicioners generally have the same qualms as Hossfeld and Pfleider about the unethical aspects of double blind studies using actual patients. However, their reasons are opposite; they question the ethics of administering a chemotherapy, in experiment, when it may well kill the patient.]

Thus certain questions whose answers would be very important for the patients remain in a scientifically gray area:

Do chemotherapeutic techniques promise greater success in the treatment of advanced organic cancer than the less toxic immune therapies which also have fewer side effects?
Do patients who are not treated at all come out better in the end?
Is it sufficient if cytostatic medicines are first prescribed only when the patient's pain becomes severe?
Can low doses of chemotherapeutic agents not basically improve the patient's outcome?
MALIGNANT SCIENCE

Only a lack of scientific imagination, as Abel thinks, has hindered the clarification of these questions up to now. One of his proposed models might serve to lift the veil of secrecy: patients with advanced organic cancer who are not yet in pain from their tumor could be tested in two groups. One group would receive cytostatic agents, the other immunotherapeutic remedies. The ethical dilemma could be resolved by giving the patients in the second group chemotherapeutic agents if the onset of symptoms demands it.

Bio-statistician Abel stands too close to the rational ideal of his mathematical discipline for his criticism of chemotherapy to be characterized as "advocacy of dubious therapies." He was forced into this reckoning by the dogmatic rigidity of the chemotherapists and their "excessive optimism." Says Abel: "They are painting themselves into a corner."

Those who have been scolded by him have up to now given the erstwhile number cruncher short shrift. More recently, as Abel's cynicism has been more and more perceptible between the lines, oncologists Hossfeld and Pfleiderer have "ended all readiness for dialogue with the author."

Perhaps there is more openness to dialogue on the part of foreign tumor experts. At the Fifteenth International Cancer Congress, which opens on Thursday of this week in Hamburg with about 8,000 specialists from all over the world, the book of Cain will be available in an English translation.

FAIM.

Provocative Theses at the Hamburg Cancer Congress

Chemotherapy Almost Useless in Treating Advanced Organic Cancer

Article from Der Spiegel, 33/1990, 174-176

(This translation provided by People Against Cancer, Otho, Iowa)

For ten years Ulrich Abel, 38, has served the West German cancer doctors as a "number cruncher" (his own expression). This graduate mathematician and PhD in epidemiology has been helping clinicians carry out their cancer investigations. His knowledge of method was in demand, and his relations with cancer experts were excellent.

This past spring, however, the Heidelberg biostatistician himself took up pen and brought out a small book with the title: Cytostatic Therapy of Advanced Epithelial tumors A Critique (Hippocrates Verlag, Stuttgart. 112 pages. 28 marks). Since that time Abel has become a pariah for many West German cancer specialists. Abel admits that in some cases he is "no longer invited to participate" in new research.

For a year this researcher, working in the Heidelberg/Mannheim tumor Center, looked through essentially "all the literature" that deals with chemotherapy ("several thousand articles"). The findings of foreign chemotherapy researchers were perused by Abel as pertinaciously as those of West German oncologists. In addition, he sent self-addressed envelopes to 350 cancer experts and cancer centers everywhere in the world in order to track down additional anti-tumor medication research which had not yet appeared in the cancer (oncology)journals.

Abel expresses in a single word the outcome of his research: "Appalling."

In the light of his year-long investigation, Abel concludes that "faith in the efficacy of chemotherapy" in the minds of many physicians is clearly a "fixed dogma" which cannot withstand the acid test of strict science.

What for this employee of the Heidelberg tumor Center was initially just a suspicion became a certainty when he had finally put the puzzle together: the weapon of chemotherapy has remained dull in the hands of cancer fighters. Even after decades of clinical application and therapeutic research the cellular poisons (cytostatics) of cancer therapy "in broad areas" of cancer therapy have "misfired."

The scientists' findings show that most kinds of cancer treatment, which are so productive of side effects, are disappointing for the patient, and for two reasons: 1) Chemotherapy is incapable of extending in any appreciable way the lives of patients suffering from the most common organic cancers. 2) Even the palliative effect of these medications, supposedly improving the quality of life of the patient, rests on shaky scientific ground.

The Heidelberg renegade could have been described as frivolous if his exposure of chemotherapy had not turned out to be appropriately differentiated. For nothing is harder for physicians in daily clinical practice than to dispel the inevitable fears of patients about chemotherapy. Hence the tumor researcher shrugs off reproaches made against his book by some West German cancer bigwigs, even before it had seen the light:

"Abel's verdict against the medicinal treatment of cancer is emphatically untrue for various kinds of lymph cancer, Hodgkin's Disease, leukemias, sarcomas, and testicular cancers in the male. These kinds of malignancies can be cured by chemotherapy with a high degree of

probability, especially in children - an undisputed success. But these are, in any case, only a very small part of the new cases of cancer diagnosed every year."

"Abel's doubts are not directed against chemotherapy when it is used in support of a curative operation, in order to shrink the tumor beforehand; nor do they apply to chemotherapy used prophylactically after an operation, to prevent a relapse (as an adjuvant)."

"A scientific wasteland" is how Abel describes the chemotherapy of "advanced epithelial malignancies." This group includes almost all organic cancer in which a potentially curative operation is no longer possible, because the tumor has already metastasized, or has recurred after a course of treatment (relapse). These kinds of tumors constitute at least 80% of all deaths from cancer every year.

In advanced small-cell lung cancer it is possible that cellular poisons may extend life somewhat. But the benefit is very slight several months on the average.

And neither in breast cancer nor in stomach cancer, neither in intestinal, bladder, or pancreatic cancer is this true when the case is advanced and metastasized. The low efficacy of medicinal antitumor therapy, in the view of the Heidelberg researcher, "is something of which neither the public nor the greater part of practicing physicians are particularly aware."

According to Abel, chemotherapy is recognizably not in a position to appreciably prolong the lives of patients. At least, there is no conclusive scientific evidence for it. Such evidence will become available when the survival rates of patients under chemotherapy can be systematically compared with those of untreated cancer patients within the framework of controlled clinical trials.

But such a procedure has no chance of acceptance by ethics commissions made up of physicians. "One cannot leave untreated a patient whose cancer is treatable with chemotherapy," state the West German experts, Dieter Karl Hossfeld and Albrecht Pfleiderer, "just to find out if he might not survive just as long without therapy." The benefits of chemotherapy are assumed axiomatically but not proven.

Also the fact that under chemotherapy the tumor mass shrinks or temporarily disappears completely (partial or complete remission) is, in Abel's view not a good sign. For the remaining tumor cells which resist the effect of the medication sometimes grow much faster afterwards.

A connection between "response," meaning shrinking of the tumor tissue, and improved survival, which many physicians see as the justification for chemotherapy, cannot be documented in the literature. "Surprisingly often," the Heidelberg biostatistician finds, the opposite occurs: patients in whom the medicine had no effect on the tumor survive longer.

According to Abel's findings, the second axiom of chemotherapy, the palliative effects of cytostatic medicines, also rests on scientifically shaky ground. Reliable studies, which might substantiate this belief for the majority of patients (exceptions are possible), according to Abel "are not yet to be found." The least one can say is that older research in the 1970s reached the opposite conclusion: highly aggressive chemotherapy undertaken prematurely

(in, for example, patients with lung cancer) shortened the survival time as compared with patients in whom chemotherapy was first instituted only with the onset of pain and which was conducted less aggressively.

The US FDA has yet to license a cancer remedy on the basis of improved quality of life, since no evidence in support of such a claim has yet been demonstrated. Despite this, according to the observations of Abel, tumor patients are often bombarded with cellular poisons at a time when the tumor in the body is still painless.

Some of the reasons for the "routine" use of toxic assaults on the body, Abel maintains, have to do with a diffuse "belief" of physicians in the efficacy of their therapy. Above all, badly informed physicians start with the attitude, often urged on by their desperate patients, that they should commence with an "aggressive therapy, causing many side effects" "at an early stage" and without the patient himself complaining of "substantial pain."

Behind this willingness of clinicians to fire away, there is often a compulsion to conduct research. Patients who are not suffering any pain are dragged at an early stage into chemotherapy because their treatment can be conducted as part of a clinical trial; but here, in Abel's view, it is hardly possible to give the patient an "individualized therapy, oriented toward his own specific complaints."

Aggressive doses of cytostatics, moreover, meet the physician's need for legitimation. The higher the dose, the better the prospect that the tumor will shrink under the effect of the cellular poison; hence maximal therapies often have the desired outcome. A victory over the tumor seems to have been reached when it remits partially or completely - even though ultimately this is no victory for the patient at all. States Abel, "there is not yet any perceptible tendency in medicine to refrain from trials with high doses."

The chemotherapy of advanced organic cancer is stuck in a blind alley out of which "an exit will be achieved only in small steps and not without some painful insights." Oncology, as the researcher puts it, has "up until now failed to provide an unobjectionable scientific basis for cytostatic therapy in its presently dominant form."

The thesis of the efficacy of cellular poisons, and the "overwhelming dominance of chemotherapeutic research" which it has spawned, may, in Abel's judgment, be seen in the future as "one of the greatest missteps ever taken in oncology and the one with the most tragic consequences."

The change of direction which is "urgently needed" in the patient's interests runs smack up against the various structures which have been erected in the meantime. About 90% of research capacity, in Abel's view, is tied in with ongoing chemotherapeutic investigations. The earnings of the pharmaceutical industry from anti-tumor medications amount to half a billion marks every year. Many cancer researchers get up to 1000 marks from the suppliers for each documented case they treat.

Alternative methods of treatment, such as possibly immune therapy, scarcely make it into the running, since many physicians lack knowledge of them. "Research proposals along these lines," as Abel ascertained over and over again during his years of consulting work, hardly get a hearing in new research plans.

So the other side has a hard time getting to the table. The advocates of immunotherapeutic approaches, or of certain other unconventional anticancer methods, are generally reluctant to let their therapies be tested in comparison with chemotherapy in controlled clinical trials.

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"It's Not Black and White" Professor Dieter Kurt Hossfeld on the Advantages & Disadvantages of Chemotherapy

(article from Der Spiegel, 35/1990, 203-205) (this translation provided by People Against Cancer, Otho, Iowa)

Dieter Kurt Hossfeld is the Head of the Division of Oncology and Hematology of the Hamburg University Clinic in Eppendorf. He was chairman of the National Organizing Committee for the Fifteenth International Cancer Congress in Hamburg. The Congress, attended by more than 10,000 experts from all over the world, saw, inter alia, an intensive debate over the benefit of chemotherapy - a problem which was discussed in Der Spiegel (33/1990) before the opening of the Congress. Hossfeld, 52, who in his clinic deals primarily with the application of chemotherapy, has hitherto been considered one of the preeminent spokesmen and advocates of this treatment. At the Hamburg World Congress he startled many physicians by his extremely critical comments about this therapeutic mode, whose efficacy is disputed by many cancer specialists.

Spiegel: Professor Hossfeld, in the past you have often given a sharp rebuke to critics of chemotherapy. Here at the International Cancer Congress in Hamburg you, for the first time, warned incisively against the abuse of chemotherapy. Have you been turned from a Saul of chemotherapy into a Paul?

Hossfeld: You could formulate it that way, and I can't stop you. In any case I wasn't jolted into this by the Congress, and certainly not by any critical article in your journal.

I was one of the very first in Germany to get into chemotherapy. In the early 1970s I spent some time in the USA and returned from there to Germany with considerable optimism about the benefits of chemotherapy. But in the past 20 years I have experienced not only the blessings but also more and more, the limitations of this therapy.

Spiegel: At the Congress you stated that many physicians are insufficiently qualified to practice chemotherapy and that cancer medicine has taken too long to acknowledge that chemotherapy can only seldom be curative; that cellular poisons have in the past been employed too frequently, and often in the wrong way.

Hossfeld: In retrospect one must now state that there was an unjustified euphoria; the possibilities of chemotherapy were overrated. Now we have learned that even chemotherapy fails to extend the lives of many patients. Very often this therapy can only be used as a palliative, to reduce pain and to improve the patient's quality of life.

In Germany we were extraordinarily hesitant to accept this revised view; even now this insight into the limits of this therapy is less widespread than it should be.

Spiegel: Many of your clinical colleagues still seem to think that life can be prolonged in advanced cases of organic cancer.

Hossfeld: Yes, I admit that you are right. There is an information gap. One of the reasons for it is doubtless that for many years our clinical studies were based upon incorrect concepts. This we must admit in retrospect. Our research stressed rates of tumor regression and survival rates. The patients' pain under treatment, their symptoms, and their well-being were insufficiently considered.

For a decade and a half this meant that patients were subjected to chemotherapy who would not be today, since we know that the palliative effect of chemotherapy is much less than the

side effects which it inflicts on patients.

Spiegel: For cancer patients those were painful years.

Hossfeld: That is to be regretted. But I think that progress is never made without mistakes. That is what is so terrible in medicine: we can perform these trials only on people. These questions cannot be solved by laboratory experiments. They must be lived through.

Spiegel: Here you specified that even today not all cancer physicians have altered their views. Is chemotherapy always going to be applied so unreflectingly?

Hossfeld: Yes, I'm afraid so. As you know, here at the Congress I clearly warned that probably only a small proportion of the physicians who employ chemotherapy are truly qualified to do it. The greater number have neither the appropriate qualification nor the experience to use it.

I myself am one of those doctors who always tells the patient: Get a second opinion; don't be satisfied with what one doctor tells you, whoever he may be. Especially if he is in a local hospital or in private practice, where there is no special competence with chemotherapy.

Spiegel: Whoever, then, is credulous is hurt in two ways - by the disease and also by the therapy.

Hossfeld: The least you can say is that the patient runs a big risk of being treated incorrectly. He will receive one of those toxic treatments which worsens the quality of his life and possibly shortens it.

Spiegel: You say that in many kinds of cancer, cellular toxins are administered just to protect that patient from tumor-induced pain. But even in this purely palliative application mistakes are made: treatment is often started too early, the doctor seldom waits until the patient's pain becomes severe, and the dose of cytotoxic agents is often much too large.

Hossfeld: This, also, I cannot deny. Out of lack of experience many physicians start chemotherapy much too early. Here you get into the general problem of how to read the patient's indications correctly. One must not forget that with this kind of therapy we are always dealing with boundary conditions. There is no black and white. It is a large gray area. For those who understand chemotherapy the decision to use it, or not use it, is an insanely difficult one. In an acute leukemia it is comparatively easy to decide, but in a far advanced case of organic cancer it is agonizing...

Spiegel:...since the treatment involves serious side effects for the patient...

Hossfeld: Yes, since you must always be weighing whether you are really helping the patient after all.

For example, take a patient with cancer of the colon and liver metastases - in 20 to 30% of these patients chemotherapy causes an impressive reversal of the liver metastases. But you can't tell ahead of time which patient will fall into this category. And the idea that 70 to 80%

of the patients don't get any benefit from this therapy makes the decision so very depressing.

Spiegel: You have made the argument that it is "unethical" not to treat a patient whose cancer is "treatable" with chemotherapy. But isn't it just as unethical to subject seven out of ten patients to a treatment which doesn't do them any good?

Hossfeld: I wouldn't say any longer that it is unethical not to treat a patient with a carcinoma. I said that a year and a half ago, and I said perhaps more than the situation warranted.

What I meant was that in each individual case it is crazily difficult to tell the patient: "I won't treat you. I cannot guarantee you any prolongation of life." Physicians and patients should give this some thought. I want to be accepted by the patients as a helper, not just as a healer.

Spiegel: What can this help consist of, in the concrete case?

Hossfeld: Not necessarily in extension of life, although that may be possible in some cases: I am thinking, for example, of a rapidly growing breast cancer with metastasis to the liver. For perhaps 30 to 50% of patients, help consists in my ability to palliate their pain with chemotherapy: when the patients have pain due to metastasis to the bones, within two to three weeks after the onset of chemotherapy these pains are drastically reduced, even though, objectively speaking, the damage to the bones is the same as before.

The same goes for patients who come to the clinic with serious breathing difficulties due to a large bronchial carcinoma; within a few days of the commencement of chemotherapy they can breathe again.

Spiegel: For the remaining 50 to 70% do you take into consideration the fact that the therapy doesn't do them any good and may actually be harmful?

Hossfeld: A high price!

Spiegel: How can you sleep at night knowing that GPs are doing chemotherapy without being in any way qualified? Are the appropriate physicians' organizations willing to tolerate this openly because they are thinking of the economic consequences for the physicians? You yourself, here at this Congress, characterized this situation as "grotesque." Do cancer patients really have to suffer in order to better the income of the attending physician?

Hossfeld: That is, of course, a hairy situation. I am afraid that I did say such a thing. But I will not exclude the possibility that the majority of inadequately qualified physicians who employ chemotherapy do so above all to help their patients. Unfortunately, it cannot be denied that chemotherapy drags on for a long time, and the GPs who employ it retain the patient in their practice for months and months. And you can't get away from the fact that, with the increasing numbers of physicians, there is a genuine battle for patients.

I reproach the Bundeskammer (the governmental licensing body for physicians) above all; despite intensive representations on the part of medical oncologists, it has not yet created, or even feels it necessary to create, a special qualification or catalog of criteria for physicians

who must employ chemotherapy.

Spiegel: Even at this Congress the demand was raised that chemotherapy must help the patient to live - not just keep him barely alive. This must mean, at the very least, that a turning point has been reached with respect to the so-called "high dose" treatment, and also with respect to unusually aggressive treatment with highly toxic substances. But in many clinics such aggressive therapies are still routine.

Hossfeld: High-dose therapy cannot just be condemned across the board. In certain cases we must avoid being paralyzed with fear - like the rabbit confronting a snake. We must try to do more, even if in some cases we cannot effect a cure.

Spiegel: Isn't this a sort of Russian Roulette for the majority of patients?

Hossfeld: The decision to undertake this therapy is not one we take sitting at our desks; every university clinic has an ethics commission for this, with participation by lawyers, theologians, physicians, and psychologists.

Spiegel: And representatives of the patients also?

Hossfeld: No, there are no representatives of patients. You may be right to criticize this, but I don't know of a single ethics commission in the world with participation by patients or former patients. Perhaps this should be rethought.

Spiegel: What does high-dose treatment do to the patient?

Hossfeld: It doesn't inevitably mean greater subjective toxicity - meaning nausea, vomiting, falling out of hair, or damage to the mucous membrane of the bladder. As concerns the lessening of nausea and vomiting, in the last 18 months we have made substantial progress on this.

But I admit that high-dose therapy has not led to any substantial increase in the patient's life expectancy.

Spiegel: Why, then, are these therapies employed?

Hossfeld: There are new medicines now which we must test out in low, normal, and high doses. In other words...

Spiegel: ...these therapies are not individualized and adjusted to the patient. Rather the decisive factor is the abstract compulsion to do research.

Hossfeld: For the types of high-dose therapy which we already know are likely to involve higher objective toxicity we will select patients with a bad prognosis, with demonstrably rapid and aggressive forms of the disease.

Spiegel: With the result that these patients will have a pretty thin time of it during the last months of their lives?

Hossfeld: That cannot be excluded. But who can say whether or not they have benefited from the therapy? That is my problem. There is a 50% chance that the patient will benefit from the treatment with a reduction in tumor size, that he will breathe easier, and that his jaundice will disappear. He might even live longer as a result, but I don't know this ahead of time.

This translation was provided by:

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