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Assessment of trends in childhood cancer incidence

Eva Steliarova-Foucher and colleagues (Dec 11, p 2097)[1] analysed data on cases of cancer registered in children and adolescents across Europe over the period 1970–99. They report that registrations have been rising at an accelerating rate, and interpret this as clear evidence of a generalised increase in the underlying incidence of cancer in children and adolescents.

Cancer registration is a complex and dynamic process which, in line with changing health-care systems around the world, continues to evolve and improve. Hence, interpretation of temporal cancer morbidity trends by means of cancer registrations presents difficulties, since ascertainment varies not only with cancer type, registry, and age, but also with time. For childhood cancers, where ascertainment is generally more complete than at older ages, its comparative rarity (around 0·5% of all malignancies) means that small changes can have a substantial effect. In most European countries, cancer registration remains voluntary, and national coverage in some countries (eg, France, Italy, Spain) has yet to be attained. In the UK—which dominates the European analysis, particularly in the earlier decades where it accounts for about 49% of the data in the 1970s—registration was recognised to be incomplete in the 1970s and 1980s, and regional variations were held responsible for several geographic patterns.[2,3] The subsequent improvement in childhood cancer registration was partly reliant on the roll-out of the UK Childhood Cancer Study Group (UKCCSG) centres across the UK—about 90% of children with cancer are now treated by UKCCSG clinicians.[4]

The fact that increases were seen across "virtually all neoplasms"[1] reassuringly supports the view that generalised improvements in registration have occurred. Indeed, given the amount of work in this area, it would be worrying if progress had not been made. Perhaps the data are now sufficiently well collected to permit temporal trends in childhood cancer incidence to be monitored using the current data as the baseline from which to work.

We declare that we have no conflict of interest.

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Incentives for research on neglected disease

There were various distortions and inaccuracies in Andrew Farlow's review (Dec 4, p 2011)[1] of our book.[2] In *Strong medicine: creating incentives for pharmaceutical research on neglected diseases,* we propose that donors commit in advance to purchase vaccines for poor-country diseases (like malaria) as a way of spurring research and development (R&D) on these diseases and ensuring that, if developed, these vaccines reach those who need them. Farlow agrees there is a paucity of R&D targeting poor-country diseases, but advocates much more radical changes.

Farlow's description of our proposal as a "nip and tuck" solution can only be understood when you realise what he is proposing as an alternative. Our objective is to replicate, for poor-country diseases, the mixture of direct financing of research (by governments or groups like the Wellcome Trust) and market incentives, which generate pharmaceuticals for rich-country diseases. At the moment, direct financing for research on poor-country diseases exists through programmes such as the International AIDS Vaccine Initiative.[3] Although more funding of this type would help, a major stumbling block remains the absence of market incentives to turn basic research into useable products. Advance purchase commitments would provide this type of incentive. Farlow, however, advocates substantial changes to the system of intellectual property rights—at least for poor countries.

The R&D system for rich-country pharmaceuticals is imperfect, and debate over how the entire pharmaceutical R&D system should be structured is certainly useful. However, if we think we should move to a system akin to open source software for pharmaceuticals, why should we do so just for products for the poor? If the system is not good enough for rich countries, why is it good enough for poor countries?