The contention of Kahlenborn et al that low-dose OCs are associated with greater risk of breast cancer than are high-dose regimens is not supported by 2 of the 3 references that they cite or by other key studies.\(^1\) Specifically, the Oxford pooled analysis found that hormone dose was not associated with breast cancer risk for last use of OCs less than 5 years ago and 5 to 9 years ago, but showed a weak inverse trend with greater dose for last use 10 or more years ago. However, the risk ratios by dose were weak and the confidence intervals overlapped those of women who had never used OCs (Appendix 62). The WHO Collaborative Study found no consistent differences in risk by dosage or type of estrogen or progestin used.\(^2\) Only the study by Rookus et al of 918 matched cases and controls aged 20 to 54 years who were enrolled from 1986 to 1989 reported a higher risk of breast cancer with low-dose OC use for more than 10 years (odds ratio, 2.9; no confidence interval provided), but this was based on only 32 exposed cases and 12 exposed controls. Further, Althuis et al concluded (from a population-based study of 1640 patients with breast cancer aged 20-44 years and 1492 matched controls enrolled from 1990 to 1992) that “newer low-potency/low oestrogen dose oral contraceptives may impart a lower risk of breast cancer than that associated with earlier high-potency/high-dose preparations.” Finally, a recent population-based study of 4575 cases and 4682 controls enrolled from 1994 to 1998 conducted by Marchbanks et al\(^1\) showed no association with low-dose OCs for women aged 35 to 64 years (on the basis of 1460 exposed cases and 1560 exposed controls), for women aged 35 to 44 years (on the basis of 836 exposed cases and 853 exposed controls), and for women aged 35 to 44 years who used low-dose OCs for 10 or more years (on the basis of 153 exposed cases and 154 exposed controls). There were also no consistent differences in risk according to the type of progestin.

It is important to stress the difference between relative risk (a measure of association that is important for assessing causality) and absolute risk (a measure of the actual effect of an exposure in a population). Although evidence shows an increasing relative risk of breast cancer with OC use, the absolute (or excess) risk of breast cancer associated with OC use is estimated to be very small. As we noted, the Oxford pooled analysis estimated that the excess number of cases of breast cancer expected to be diagnosed up to 10 years after stopping OC use among 10,000 European or North American women is 0.5 cases for OC use from age 16 to 19 years, 1.5 cases for OC use from age 20 to 24 years, and 4.7 cases for OC use from 25 to 29 years. Thus, eliminating OC use would be expected to prevent only a small fraction of cases of premenopausal breast cancer. Further, although “premenopausal women often experience worse outcomes than postmenopausal women,” the best evidence to date indicates that breast cancers that develop in OC users are less advanced clinically than cancers diagnosed in women who never used OCs.

We think that the current literature justifies our conclusion regarding the lack of a major clinical role for OCs in the etiology of breast cancer. Newer formulations and schedules will need to be assessed for their association with risk. As with all clinical decisions, risks and benefits must be carefully weighed, and we have outlined the major factors for OCs in our Concise Review. We agree that women “deserve to be provided with the most accurate and up-to-date information on the potential risks associated with OCs.” They also deserve a balanced discussion that includes both risks and benefits of OCs, and these risks and benefits must be put into a clinically meaningful context. This was the goal of our review.

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**CORRECTIONS**

**Incorrect column heading in table:** In the article by Moeller et al entitled “Urine Drug Screening: Practical Guide for Clinicians,” published in the January issue of *Mayo Clinic Proceedings* (Mayo Clin Proc. 2008;83(1):66-76), columns 2 and 4 of Table 3 on page 69 were mislabeled. Those columns should read as follows: “Potential agents causing positive results.”

**Incorrect dates:** In the article by Wysokinski et al entitled “Periprocedural Anticoagulation Management of Patients With Nonvalvular Atrial Fibrillation,” published in the June 2008 issue of *Mayo Clinic Proceedings* (Mayo Clin Proc. 2008;83(6):639-645), the dates of the study were incorrect in the “Patients and Methods” section of the article on page 640, left-hand column, first paragraph. The sentence should read as follows: “Consecutive patients referred to the Thrombophilia Center during the 7-year period, January 1, 1997, to December 31, 2003, who were receiving long-term anticoagulation therapy and had nonvalvular AF were eligible for inclusion; 97% consented to participate.”