encouraged to develop advance directives with their patients during routine visits, free from the pressures of the acute care setting.

Ellen L. Toth, MD
Satvir Gill, MD
Diane Godkin
Kwoc-Choy Lee, MD
Division of Endocrinology
and Metabolism
Department of Medicine
University of Alberta
Calgary, Alta.

References

1. Singer PA, Robertson G, Roy DJ. Bioethics for clinicians: 6. Advance care planning. *CMAJ* 1996;155(12):1689-92.
2. Miles SH, Koepp R, Weber EP. Advance end-of-life treatment planning. *Arch Intern Med* 1966;156:1062-8.
3. Landry FJ, Kroenke K, Lucas C, et al. Increasing the use of advance directives in medical outpatients. *J Gen Intern Med* 1997;12:412-5.
4. Cantril H. *The pattern of human concerns*. New Brunswick (NJ): Rutgers University Press; 1965.
5. Molloy DW, Mepham V. My health care — I decide. In: *Let me decide* [video series]. 2nd rev. Hamilton (ON): McMaster University Press; 1990.

Breast cancer guidelines

All physicians will be grateful to Dr. Maurice McGregor and his many colleagues on the Steering Committee on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer for their prodigious effort in producing the supplement "Clinical practice guidelines for the care and treatment of breast cancer: a Canadian consensus document" (*CMAJ* 1998;158[3 Suppl]:S1-83). My remarks should be considered a part of the refinement process that now begins.

Page S5, in guideline 1, "The palpable breast lump: information and recommendations to assist decision-making when a breast lump is detected" (*CMAJ* 1998;158[3 Suppl]: S3-8), emphasizes that physicians can often distinguish, by clinical examination, benign from malignant breast lumps and that practice improves performance. Unfortunately, "often" is not good enough for Canadian women. The clinical examination can never reach the level of accuracy of the gold standard, excisional biopsy. Timely access to excisional biopsy is available to everyone in Canada, with the possible exception of those living in remote communities.

Canadian women will accept nothing less than the gold standard. Canadian physicians and surgeons should insist on the same and may be penalized if they provide anything less.[1]

Somewhere on page S5 the following message should be prominently displayed: "Any clinically palpable lump (mass lesion) that is solid on aspiration must ultimately be proven to be cancer or not cancer by excisional biopsy." This recommendation applies to all lumps, even apparently typical fibroadenomas in adolescents and women in their early 20s, because breast cancer does occur — if only rarely — in these age groups. Excisional biopsy could save many physicians and patients a lot of grief.

Leo Mahoney, BA, MD, MS
Associate Professor
Department of Surgery
University of Toronto
St. Michael's Hospital Breast Centre
Toronto, Ont.
Received by email

Reference

1. Osuch JR, Bonham VL. The timely diagnosis of breast cancer. Principles of risk management for primary care practitioners and surgeons. *Cancer* 1994;74(1 Suppl):271-8.

I read with interest the consensus guideline "Investigation of lesions detected by mammography" (*CMAJ* 1998;158[3 Suppl]:S9-14). I was involved in the peer review of this document and raised certain concerns at that time. Although the authors addressed some of my comments, a few problems have remained unanswered.

- On page S11 it is stated that "[i]n all but completely straightforward cases . . . the opinion should be obtained of a second radiologist who is also experienced in mammographic interpretation (level V evidence [i.e., opinion of the guideline authors])." There are no studies to support any benefit from such an approach. I remember that the Canadian National Breast Screening Study (NBSS) followed such a policy, but in my own experience, 2 cases that I identified and that were not confirmed by another radiologist were found to be cancer at the next screening. The authors allude to 2 references,[1,2] both of which apply to double reading of *all* cases, not only the doubtful ones. I am certain that the routine checking of only doubtful mammograms by a second experienced radiologist will decrease the breast cancer detection rate, even though it may cut back on recalls.
- In the section on the report of mammographic work-up (p. S11), 4 categories of risk stratification are presented. It is stated that the classification is similar to that of the American College of Radiology (ACR). However, the ACR classification has 5 categories, category 1 representing normal results. Eliminating the "normal" category changes the risk value of the others: category 3 in the ACR classification signifies probably benign lesions, whereas here it refers to probably malignant lesions. Given that the ACR system is an internationally accepted categorization, it is confusing and possibly dangerous to change the numeric assignment of the categories.
- The discussion of attribution of a numeric percentage risk within categories is confusing. Page S11 states that the percentage has "no precise quantitative meaning and is intended only to give meaning to the expressions 'low,' 'intermediate' and 'high' risk," yet on page S12 for category 3 abnormalities it is stated that to perform a biopsy,

"the estimated risk of malignancy should be at least 2%." In other words, if the estimated risk is 1%, a biopsy should not be performed, but if the risk is 2%, the procedure should be done. However, it is probably impossible to determine a 1% increment of risk from mammographic results.

- Finally, on page S12 under category 3 abnormalities it is stated that "[i]n the case of a suspected papillary lesion, the patient should also be referred for open surgical biopsy because of the difficulty in pathologically interpreting the core specimen (level V evidence)." This recommendation is not supported by any published literature. It may be true that there are more important lesions that should not undergo core biopsy. Parker and Jobe, the pioneers of breast core biopsy, stated that the only patients for whom they do not routinely request core biopsy are those suspected of having radial scar.[3] They also stated that core biopsy of granular or cotton ball calcifications is controversial because they are a marker of diffuse disease (benign or malignant).

Pasteur Rasuli, MD
Department of Radiology
Ottawa General Hospital
Ottawa, Ont.

References

1. Anderson ED, Muir BB, Walsh JS, Kirkpatrick AE. The efficacy of double reading mammograms in breast screening. *Clin Radiol* 1994;49:248-51.
2. Anttinen I, Pamilo M, Soiva M, Roiha M. Doulbe reading of mammography screening films — one radiologist or two? *Clin Radiol* 1993;48:414-21.
3. Parker SH, Jobe WE. *Percutaneous breast biopsy*. New York: Raven Press; 1993. p. 62-3.

[The chair of the Steering Committee responds:]

On behalf of the Steering Committee I thank these contributors for their suggestions. The following comments are my own.

I do not think that Dr. Leo Mahoney and the Steering Committee disagree, although we have not used the words Mahoney suggests. The guidelines say that "once a lump or *suspicious* change in breast texture is discovered, it is necessary to establish whether it is malignant or not" and "a *clinically suspicious* lump requires further investigation" [emphasis added]. However, "the principle is to establish a reliable diagnosis using the minimum of procedures." We surely should not have recourse to excisional biopsy in the absence of suspicion.

Many of the suggestions made by Dr. Rasuli in his review of an earlier draft of one of the guidelines were incorporated. Some of his points, the remaining problems to which he refers, are valid but debatable and were not incorporated. This situation is inherent in a consensus document. Level V evidence is, by definition, the unsupported opinion of the authors.

Maurice McGregor, MB, BCh
Chair
Steering Committee on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer
Professor of Medicine
McGill University
Montreal, Que.

Updating the insulin lispro file

I suspect that a delay between the time of writing and the date of publication of the article "Insulin lispro (Humalog), the first marketed insulin analogue: indications, contraindications and need for further study" (*CMAJ* 1998;158[4]:506-11), by Drs. Anuradha L. Puttagunta and Ellen L. Toth, may be responsible for the inclusion of only studies published up to 1996. However, more recent studies have addressed a number of the questions raised in that article.

The efficacy of insulin lispro in improving the levels of hemoglobin A_{1c} ($HgbA_{1c}$) has been demonstrated recently; the analogue is particularly effective when the basal insulin and the meal plan are adjusted. Ebeling and associates[1] reported that when

Submitting letters

Letters must be submitted by mail, courier or email, not by fax. They must be signed by all authors and limited to 300 words in length. Letters that refer to articles must be received within 2 months of the publication of the article. *CMAJ* corresponds only with the authors of accepted letters. Letters are subject to editing and abridgement.

Note to email users

Email should be addressed to **pubs@cma.ca** and should indicate "Letter to the editor of *CMAJ*" in the subject line. A signed copy must be sent subsequently to *CMAJ* by fax or regular mail. Accepted letters sent by email appear in the Readers' Forum of *CMA Online* (**www.cma.ca**) promptly, as well as being published in a subsequent issue of the journal.

Pour écrire à la rédaction

Prière de faire parvenir vos lettres par la poste, par messager ou par courrier électronique, et non par télécopieur. Chaque lettre doit porter la signature de tous ses auteurs et avoir au maximum 300 mots. Les lettres se rapportant à un article doivent nous parvenir dans les 2 mois de la publication de l'article en question. Le *JAMC* ne correspond qu'avec les auteurs des lettres acceptées pour publication. Les lettres acceptées seront révisées et pourront être raccourcies.

Aux usagers du courrier électronique

Les messages électroniques doivent être envoyés à l'adresse **pubs@cma.ca**. Veuillez écrire «Lettre à la rédaction du *JAMC*» à la ligne «Subject». Il faut envoyer ensuite, par télécopieur ou par la poste, une lettre signée pour confirmer le message électronique. Une fois une lettre reçue par courrier électronique acceptée pour publication, elle paraîtra dans la chronique «Tribune des lecteurs du *JAMC*» d'*AMC En direct* (**www.cma.ca**) tout de suite, ainsi que dans un numéro prochain du journal.