

3. Haldeman S, Kohlbeck FJ, McGregor M. Risk factors and precipitating neck movements causing vertebrasilar artery dissection after cervical trauma and spinal manipulation. *Spine* 1999; 24:785-94.
4. Schievink WI, Mokri B, Piepgras D, Parisi Gilbert P. Cervical artery dissections associated with chiropractic manipulation of the neck: the importance of pre-existing arterial disease and injury [abstract]. *J Neurol* 1996;243(Suppl 3):92S.

Breast cancer guidelines

As one of the authors of the Canadian Society of Surgical Oncology consensus statement on sentinel lymph node biopsy for breast cancer,¹ I agree with most of the recommendations put forth by Jacques Cantin and colleagues.² However, there are 2 philosophical questions I would like to ask the authors in particular and the readership of *CMAJ* in general.

Cantin and colleagues state that “a surgeon who performs breast cancer surgery infrequently should not perform [sentinel lymph node] biopsy.”

Should such surgeons be allowed to operate on breast cancers at all? If a surgeon cannot perform a sentinel lymph node biopsy reliably then why do we assume that he or she can safely perform a segmental mastectomy or axillary node dissection, procedures that, in my opinion, are even more complicated? We do not publicly identify such stringent criteria for performing other complex procedures (for which surgical volumes have clearly been shown to affect morbidity and mortality), such as the Whipple procedure for pancreatic cancer and the total mesorectal excision for rectal cancer.

The second question concerns the recommendation that patients “should be informed of ... the surgeon’s success rate with the procedure.” This is reminiscent of the publication of morbidity and mortality rates of US cardiac surgeons on the Internet. Should the recommendation of Cantin and colleagues be broadened to include a surgeon’s rate of positive margins with segmental

mastectomy and the average number of nodes he or she excises with axillary node dissection?

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References

1. McCreedy DR, Bodurtha, AJ, Davis NL, Meterissian S, Robert J, Temple WJ. Sentinel lymph node biopsy in breast cancer. *Can J Surg* 1999;42:406-7.
2. Cantin J, Scarth H, Levine M, Hugi M, for the Steering Committee on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer. Clinical Practice guidelines for the care and treatment of breast cancer: 13. Sentinel lymph node biopsy. *CMAJ* 2001;165(2):166-73.

Psychological factors in clinical nutrition

I enjoyed reading the first article in *CMAJ*’s clinical nutrition series.¹ Perhaps this was judged irrelevant in a clin-

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ical nutrition case, but I thought that psychological factors should have been considered in the case discussion. Why exactly was Mr. B. not eating? Why did his food not appeal to him? Surely there was more going on than an inability to reach his food. Mr. B. could very well have been suffering from clinical depression; if it were properly treated, his appetite would improve and his protein-energy malnutrition would be reversed.

Bruce Williams

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Reference

1. Hoffer LJ. Clinical nutrition: 1. Protein-energy malnutrition in the inpatient. *CMAJ* 2001;165 (10):1345-9.

[The author responds:]

My article described protein-energy malnutrition as a pathologic entity with specific causes, the

most common of which by far is simple starvation. Bruce Williams's suggestion that depression could explain my patient's inadequate food intake is excellent, but he might have asked a broader question: Why do 25% or more of hospital inpatients starve in the midst of apparent plenty? Mr. B.'s story was inspired by a real case. My patient was certainly unhappy and discouraged. Who wouldn't be in his situation? No one had diagnosed psychiatric depression, but neither was it ruled out. If he was depressed, would antidepressant therapy have hastened his recovery? Possibly, but only if it did not delay or replace the holistic intervention described in the case history. Unfortunately we have no systematic information about the role of mental illness as a cause of starvation (nor, conversely, about starvation's role in precipitating or exacerbating mental illness) in hospitalized patients. Several factors are probably involved.¹ For example, patients who don't eat

enough food will predictably be micronutrient starved. Deficiency of certain micronutrients, especially folic acid, precipitates depression.² Folic acid administration improves the clinical outcome even of apparently nourished, yet depressed, patients.^{3,4} However, few starving patients are prescribed vitamin supplements.

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References

1. Sarkisian CA, Lachs MS. 'Failure to thrive' in older adults. *Ann Intern Med* 1996;124(12):1072-8.
2. Bottiglieri T, Laundy M, Crellin R, Toone BK, Carney MW, Reynolds EH. Homocysteine, folate, methylation, and monoamine metabolism in depression. *J Neural Neurosurg Psychiatry* 2000;69 (2):228-32.
3. Godfrey PSA, Toone BK, Carney MWP, Flynn TG, Bottiglieri T, Laundy M, et al. Enhancement of recovery from psychiatric illness by methylfolate. *Lancet* 1990;336(8712):392-5.
4. Coppen A, Bailey J. Enhancement of the antidepressant action of fluoxetine by folic acid: a randomised, placebo controlled trial. *J Affect Disord* 2000;60(2):121-30.

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2 x 1/2 pages, 4 clr.

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