pets — many older women choose the "quick fix" — modified radical mastectomy — and an overnight stay in hospital.

Would academic surgeons please descend from Mount Olympus and view the world through the eyes of the humble community surgeon?

David E. Leask, MD
Kitchener, Ont.

[The author responds:]

Dr. Leask's letter illustrates part of the problem described in the article "Patterns of initial management of node-negative breast cancer in two Canadian provinces" (*Can Med Assoc J* 1997;156:25-35), by Dr. Vivek Goel and associates. Mastectomy rates vary among Canadian provinces, and travel time to a radiation-therapy facility is inversely associated with the use of breast-conserving surgery in both provinces (although it is not statistically significant in Ontario). However, travel time and other variables were insufficient to explain the large difference in mastectomy rates between British Columbia and Ontario.

Everyone who sees many women with breast cancer knows that some women prefer definitive treatment by surgery if it will shorten the time they have to spend away from home. As well, we all know surgeons (and not exclusively surgeons in rural communities) who tend to perform mastectomies in older women as well as those who tend to perform mastectomies because they privately still hold the opinion that mastectomy is the better treatment. More than once a patient has told me that her surgeon gave her both options but concluded, "If you were my wife . . ."

There also is the distressing fact that some women still need radiation therapy after a mastectomy, when the risk of local or regional recurrence is high. The combination of these treatments exposes these women to a considerable risk of lymphedema.

I did not wish to patronize, and Leask's statement that all surgeons are aware that partial mastectomy and irradiation are the treatment of choice in most cases of breast cancer brings me some reassurance.

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India's hungry mosquitoes

My husband, Dr. Curtis A. Steele, and I have just returned from India. We learned all we could about malaria before the trip and followed advice, and I hope we will not acquire the disease. We would like to add some information to the article "Malaria in Canada" (*Can Med Assoc J* 1997;156:57), based on our experience.

Arriving in the Bombay airport at 2 a.m. — most flights from abroad arrive in the middle of the night — hundreds of travellers stand in line in a space where mosquitoes abound. To prevent being bitten, visitors must apply an insect repellent before landing. We did not do this and were each bitten dozens of times before arriving at the immigration desk.

Window screens are seldom used in India. During our travels we saw only one screened window, and a few more with lace serving a partial screening function. Even in our air-conditioned hotel the bathroom window had a grille, not a screen, between us and the outdoors. Screen doors do not exist — outdoors and indoors are one.

There was nothing from which to hang a bed net in any of the places we stayed, expensive hotels or otherwise. We find it impossible to imagine being in India and not being bitten by mosquitoes, unless one stays covered in a completely effective mosquito repellent.

Nancy Porter-Steele, PhD
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Received via e-mail

Cumulative patient profiles

Dr. Richard Tytus and I read with great interest the article "Physicians who keep lax records put careers in danger, college course warns" (*Can Med Assoc J* 1996;155:1469-72), by Dee Kramer. Because we are involved with the Practice Management Committee of the Hamilton Academy of Medicine, we responded to members' requests by developing a series of patient-record-management sheets, the cornerstone of which is the cumulative patient profile. As is evident from the cumulative patient profile form presented with Kramer's article, the most recent update of this form was by the University of Toronto in 1977. We designed our sheets to reflect current concerns and provide versatility for individual physicians. Physicians who would like to receive a sample copy can contact me. Multiple copies can be obtained from Colwell Systems, tel. 800 265-3375.

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No barriers in Manitoba

CMAJ's Pulse column ("Financial and geographic barriers to fee-for-service practice," *Can Med Assoc J* 1997;156:616) summarized the financial and geographic barriers to fee-for-service practice across Canada, but the information with respect to Manitoba is out of date.

Between January 1994 and October 1996, physicians new to practice in Manitoba were issued "provisional" billing numbers. However, all such numbers have now been converted to "valid and active" status. As a result, there are now no financial or geographic barriers to fee-for-service practice in Manitoba.

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Japan's smoking epidemic

I read with interest the editorial "Taxes and the tobacco wars" (*Can Med Assoc J* 1997;156:205-6), by Dr. Lawrence W. Green. A tobacco tax is a well-known means of preventing smoking and decreasing cigarette use among teenagers. In Japan, cigarettes are cheaper than in Canada. A package of Mild Sevens, the best-selling brand, costs 220 yen, or about Can$2.40.

The increase in the number of underage smokers and young women smoking is one of Japan's most important problems.[1] According to the Japan Tobacco Association, 334.7 billion cigarettes were sold in 1995.[2] The prevalence of smoking in 1995 was 58.8% among men and 15.2% among women — in other words, about 27.3 million men and 7.5 million women smoke.[3] Because of the growing popularity of foreign cigarettes, particularly US brands, thanks to advertising and vending machines, the share of the cigarette market held by Japan Tobacco Inc. has dropped from 98.5% in 1982 to 78.8% in 1995.

On Apr. 1, 1997, the consumption tax applied to cigarettes will be raised from 3% to 5%. The newspapers say that Japan Tobacco Inc. will mark up 23 of its 118 cigarette brands by 10 yen per pack, upping the price of a pack of Mild Sevens to 230 yen.

If it wants to indicate that it takes this threat to people's health seriously, the Japanese government should increase taxation by 10 yen per cigarette, not per package.

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