More on breast cancer guidelines

I was surprised that the supplement "Clinical practice guidelines for the care and treatment of breast cancer: a Canadian consensus document" (*CMAJ* 1998;158[3 Suppl]:S1-83) makes no mention of breast reconstruction and that in the accompanying booklet "Questions and answers on breast cancer: a guide for women and their physicians" (*CMAJ* 1998; 158[3 Suppl]) such surgery is mentioned only in a negative context.

Our practice for women with breast cancer who are considering mastectomy is to mention the possibility of reconstruction at the time of the surgical consultation. When performed at the time of mastectomy, reconstructive surgery may be associated with fewer problems and better patient satisfaction than if it is performed later.

Women who have undergone breast reconstruction are highly satisfied and have an improved self-image. For most patients, the limitations of the procedure in terms of shape and sensation of the reconstructed breast are far outweighed by the positive aspects, especially the natural contour (without an external prosthesis) achieved by current surgical techniques that use the patient's own tissues.

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The Steering Committee on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer should be complimented on these comprehensive and up-to-date guidelines to assist patients and physicians in reaching decisions about the treatment of breast cancer.

I found one glaring omission in the guidelines, however: the role of breast reconstruction in treatment. As a plastic surgeon, I find that some physicians and surgeons are uninformed or misinformed about the options available to women unable to undergo breast-conserving surgery. Even in the section on the "informed choice" between breast-conserving surgery and mastectomy in "Mastectomy or lumpectomy? The choice of operation for clinical stages I and II breast cancer" (*CMAJ* 1998;158[3 Suppl]:S15–21), there is no mention of discussing breast reconstruction with the patient and the role of such a discussion in a truly informed decision. I assume that the steering committee did not feel this was a subject that warranted inclusion. However, my experience with patients who have undergone breast reconstruction and even those who have simply discussed the possibility of this surgery in consultation indicates that they consider this an integral part of their treatment, both in a physical sense and in a psychosocial sense.

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Holiday Review '98
Call for Outlandish Papers

Deadline: Aug. 17, 1998

Last December *CMAJ* published its first Holiday Review issue. We hope this will become an annual tradition, but that depends on you. Last year we presented the year in review, with writers from across Canada looking back at the advances within their specialties. This year, and we admit unabashedly that we've stolen the idea from our friends at the *BMJ*, we want to take a lighter approach. Here's what they look for: "The usual cocktail of the deadly serious, the poignant, the speculative, the frivolous, and the downright barmy."

We know Canadian physicians can be as barmy as the best of them, so we are throwing down the gauntlet. Give us your weird studies, your unsubstantiated research, your outrageous anecdotal evidence, tell us why you should have been a vet or an investment banker, document the undocumented. To wit: one of the *BMJ*'s 1997 reports was entitled "Do overweight people remove their shoes before being weighed by a doctor? Consecutive study of patients in general practice." You get the idea. We are also looking for some poignant, practice-related articles.

We're seeking submissions of up to 1200 words, and outlandish illustrations are encouraged. So are group efforts — we'd love it if an entire clinic or even hospital department participated. If you would like to discuss a submission, please contact Dr. John Hoey, 800 663-7336 x2118, **hoeyj@cma.ca**, or Patrick Sullivan, x2126, **sullip@cma.ca**.

We must receive your written submissions or proposals by Aug. 17, 1998. Send them to Dr. John Hoey, Editor-in-Chief, *CMAJ*, 1867 Alta Vista Dr., Ottawa ON K1G 3Y6.

The clinical practice guidelines for breast cancer are admirable, but the document lacks one vital section. A common complication of breast cancer treatment is post-mastectomy lymphedema. This problem can be disturbing, debilitating and dangerous. Because of its late onset it can come as a shock to the woman who feels that she has survived the disease. Although there is a great deal of conjecture as to the causes, no clear mechanism has been identified. It has been suggested that it results from chronic inflammation in the lymphatic or venous channels.[1] Another school blames post-radiation changes,[2] although radiation techniques have been modified considerably over the past few years and the condition is seen in patients who have not undergone radiotherapy. Others feel that it is always associated with invasion of the lymphatic nodes. Some claim that minor damage to superficial lymphatics or back-pressure on the lymphatic nodes, with production of a high-protein lymph, is the cause.[3]

A recently completed 10-year study at the Princess Margaret Hospital indicates that for 60% of patients, relatively good reduction of the swelling can be achieved with peripheral compression pumps and binding.[4] However, the findings have been contested by practitioners who maintain that the pump is contraindicated and that manual lymphatic drainage is the key tactic.

Although it will be of little consolation to affected women, there may be some solace in the realization that because of its prevalence, interest in this condition has been rekindled and research reactivated.

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On behalf of the Society of Obstetricians and Gynaecologists of Canada (SOGC), I offer congratulations on these guidelines. I am sure they will constitute a useful resource for obstetrician-gynecologists, who see many women with breast cancer in their practices.

I was a little concerned that there was no discussion of the role and appropriateness of hormone replacement therapy (HRT) after breast cancer in postmenopausal women. There is no doubt that this remains a controversial issue about which there is little prospective scientific information. Current estimates suggest that 100 000 North American women are cured of breast cancer every year, many of whom become prematurely menopausal because of adjuvant chemotherapy. The loss of ovarian function has an adverse effect on quality of life for many of these women and significantly accelerates osteoporosis and cardiovascular disease in others. The National Cancer Institute in the US recently initiated a randomized controlled trial to evaluate the appropriateness of HRT after breast cancer to treat these problems.

The SOGC has just published a policy statement on this topic.[1] It is our position that after treatment of breast cancer, all women should receive expert personal counselling that covers prognostic factors, immediate quality-of-life issues related to estrogen deficiency, risk factors for future osteoporotic fracture and cardiovascular disease, and options for symptom control and disease prevention. It is our hope that more prospective clinical data on which to base an evaluation of the role of HRT after breast cancer will be available for future iterations of these clinical practice guidelines.

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Reference

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In the guideline "The management of ductal carcinoma in situ (DCIS)" (*CMAJ* 1998;158[3 Suppl]:S27–34), I had difficulty following the logic in the explanation for the last recommendation in the section on diagnosis (page S30). Citing the multicentre clinical trial by Fisher and colleagues,[1] in which problems in standardizing the interpretation of DCIS specimens were described, the guideline authors state that "a similar or even higher rate of misinterpretation could be expected from general pathologists working in the community" and go on to recommend that "whenever the pathologist is not highly experienced, the biopsy specimen be reviewed by a pathology service with special expertise in this area." However, this is only level V evidence, the opinion of the guideline authors.

As a "general pathologist working in the community," I find this blanket recommendation unwarranted. The DCIS cases I see form a spectrum from low to high grade. Most cases are fairly obvious and present the straightforward cytoarchitectural features of DCIS. The problem occurs in the small subset of cases at the low-

grade end of the spectrum, where the distinction between DCIS and atypical ductal hyperplasia (ADH) can be difficult because of ill-defined or arbitrary criteria that may not be very reproducible. Fisher and colleagues[1] stated that 7% of the cases were reclassified as ADH rather than DCIS on the basis of the authors' rather subjective definition of ADH as "ductal epithelial alteration approximating but not unequivocally satisfying the criteria for a diagnosis of DCIS," rather than the more quantitative but arbitrary criteria used by others.[2,3]

The 2% of cases that were reclassified as invasive and "undercalled" DCIS raise the question of whether all breast biopsy results that might be undercalled but never referred to a cancer centre (e.g., radial scars, sclerosing adenosis, ductal epithelial hyperplasia) should be reviewed by experts.

I believe that, in signing a surgical pathology report, the pathologist must take responsibility for its accuracy and should therefore determine which cases require expert consultation.

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3. Page DL, Anderson TJ. *Diagnostic histopathology of the breast*. Edinburgh: Churchill Livingstone; 1988. p. 137.

Overall, this is an excellent, much-needed document. However, I was disappointed by some of the comments about the pathologic interpretation for diagnosis of DCIS. Specifically, on page S30, the authors indicate a high rate of misinterpretation of ADH and DCIS and imply a high rate of misinterpretation by general pathologists working in the community.

As a general pathologist, I believe that 3 points need further clarification. First, I agree that distinguishing between ADH and low-grade DCIS is a problem, specifically in the case of borderline lesions between these 2 entities. Even among experienced pathologists with an interest in breast pathology, there may be a lack of concordance in such cases.[1] However, when pathologists use standardized criteria to classify these lesions, concordance is much better.[2] A recent consensus conference on the classification of DCIS[3] recommended a universally acceptable, reproducible and clinically useful system of classification, but such is not currently available.

Second, in response to the recommendation that biopsy specimens examined by relatively inexperienced pathologists be reviewed by pathologists with special expertise in this area, I think that most general pathologists *do* see ample cases of breast cancer to maintain their expertise — breast biopsy is one of the most common procedures performed in the community. Most cases of DCIS, especially the higher-grade,

Numéro des Fêtes 1998
Appel de communications farfelues

Date limite : le 17 août 1998

En décembre dernier, le *JAMC* a publié son premier numéro des Fêtes. Nous espérons en faire une tradition annuelle, mais tout dépend de vous. L'année dernière, nous avons présenté une rétrospective de l'année où des auteurs de toutes les régions du Canada ont décrit les progrès réalisés dans leur spécialité. Cette année — et nous admettons sans gêne avoir emprunté l'idée de nos amis du *BMJ* — nous visons des résultats plus légers. Voici ce qu'ils recherchent : «Le cocktail habituel de textes d'un sérieux mortel, prenants, hypothétiques, légers ou tout bonnement loufoques.»

Nous savons que les médecins du Canada peuvent être aussi loufoques que n'importe qui et c'est pourquoi nous lançons le défi. Faites nous parvenir vos études bizarres, vos recherches sans preuves, vos preuves anecdotiques outrées. Dites-nous pourquoi vous auriez dû être vétérinaire ou banquier d'affaires. Documentez ce qui ne l'est pas. Exemple : un des comptes rendus publiés dans le *BMJ* en 1997 s'intitulait «Les personnes de poids trop élevé enlèvent-elles leurs chaussures avant de se faire peser par un médecin? Étude consécutive sur des patients en pratique générale.» Vous voyez l'idée. Nous cherchons des articles prenants qui ont trait à la pratique.

Nous demandons des textes de moins de 1200 mots et nous encourageons les illustrations les plus farfelues. Les efforts collectifs aussi — nous aimerions recevoir des textes d'une clinique ou même d'un département d'hôpital au complet. Pour discuter d'un document que vous voulez présenter, veuillez appeler le Dr John Hoey, au 800 663-7336 x2118, **hoeyj@cma.ca**, ou Patrick Sullivan, x2126, **sullip@cma.ca**.

Nous devons recevoir votre texte ou votre proposition au plus tard le 17 août 1998. Veuillez les faire parvenir au Dr John Hoey, rédacteur en chef, *JAMC*, 1867, prom. Alta Vista, Ottawa ON K1G 3Y6.

comedo type, pose no special problem. The problems arise with low-grade DCIS, as described earlier, and the borderline cases will continue to pose a problem, even for experienced pathologists with an interest in this area.

Finally, the statement that the pathology assessment is critical not only to the diagnosis of DCIS but also to prognosis and choice of treatment definitely applies to high-grade, comedo-type DCIS. There is good evidence that such lesions occur frequently and will progress to infiltrating carcinoma if treated inadequately. Although we may not know as much about the natural history of low-grade DCIS, there is evidence that its clinical behaviour is less aggressive, as there is less recurrrence after excisional biopsy.[4] Even less is known about the natural history of limited foci of low-grade DCIS and ADH, although we do know that women who have these lesions are at increased risk of subsequent carcinoma. Pathologists must still strive to classify these lesions to the best of our abilities, so that clinical trials can determine their biological potential and the most appropriate management.

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We were pleased to see the publication of this supplement. However, we were disappointed that although the guideline "The palpable breast lump: information and recommendations to assist decision-making when a breast lump is detected" (*CMAJ* 1998;158[3 Suppl]:S3-8) mentioned strong family history among the factors that increase the likelihood of breast cancer (level III evidence), nowhere else in the document was there any discussion of the recently discovered breast cancer susceptibility genes. It is now known that mutations in 2 recently identified genes, *BRCA1* and *BRCA2*, confer a risk of breast cancer. Mutations in these genes appear to account for 5% to 10% of all cases of breast cancer. Identification of such mutations provides important information about the risk of additional neoplasms in the affected individual and other family members. This risk includes the association of breast cancer with ovarian cancer in predisposed families and the risk of breast cancer among male members of these families. Furthermore, in some families with familial breast and ovarian cancer, there could be increased predisposition to colerectal cancer.[1]

The guidelines document also indicates that the risk of breast cancer increases with age. In 1997 in Canada the cumulative risk of breast cancer was approximately 11% by age 70 years.[2] This risk is much higher in families known to carry one of the mutant alleles. The cumulative risk for women carrying *BRCA1* mutations may be as high as 85% by age 70 years.[3]

The Cancer Genetics Studies Con-sortium recently published its recommendations for follow-up care of people with an inherited predisposition to breast cancer because of mutant genes.[4] The consortium concluded that identifying people with the relevant mutations is a necessary first step in improving prevention and treatment. Early breast and ovarian cancer screening was recommended for people with *BRCA1* mutations and early breast cancer screening for those with *BRCA2* mutations.

The management of breast cancer should surely include its prevention among high-risk individuals. We suggest that the steering committee seek the advice and involvement of the genetic community for the next version of these guidelines.

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[The chair of the steering committee responds:]

On behalf of the Steering Committee on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer I thank these contributors for their suggestions. The following comments are my own.

In reply to Drs. Mahoney, Brown and Godfrey, I would point out that breast reconstruction and lymphedema were high on the approximately 20 topics first considered by

the steering committee. However, 10 had to be chosen, and neither of these made the final list. Both are included among the topics that the steering committee has proposed for the (hoped-for) successor to these guidelines.

Like breast reconstruction and lymphedema, hormone replacement therapy could not be included in the first set of guidelines but is high on the list of topics for the next set. The policy statement of the SOGC will be valuable at that time, and I thank Dr. Reid for drawing it to our attention.

Probably neither Dr. Rieckenberg nor Dr. Ramsay disagrees with the general thrust of the paragraph in question, which can be summarized as follows: (1) The histopathological diagnosis of DCIS is often difficult — even the pathologists of a major clinical trial had difficulty. (2) Experience, in the form of a substantial DCIS caseload, presumably helps interpretation. (3) If there are any pathologists who lack such experience, they should not hesitate to refer specimens to a centre with special expertise. Naturally, it is the pathologist who must determine when expert consultation is needed.

I thank the co-participants of the Maritime Hereditary Cancer Programme for their excellent summary on genetic risk, but ask for their patience with us guidelines writers. We did not include hereditary risk factors among the first 10 topics, although we probably should have. I have little doubt that this topic will be tackled in the second round.

I am grateful for all of these helpful comments and those that were published in an earlier Letters section of *CMAJ*. I consider this correspondence a continuation of the Canada-wide consultation that was an intrinsic part of the development of the first 10 guidelines. All of these comments will be considered by the steering committee as it starts round 2, and they will all help to further mould a Canadian consensus.

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This list works. Use it

Dr. Brian F. Rudrick, in his letter "Familial abuse: a multifaceted problem" (*CMAJ* 1998;158[7]:866-7), presents good arguments but misses the point. Yes, women also abuse, and many items on "The eight types of abuse" list (*CMAJ* 1997; 157[11]:1557-8) can be applied to women who abuse. However, the list and the accompanying article, "More than meets the eye: recognizing and responding to spousal abuse" (*CMAJ* 1997;157[11]:1555-6), by Fern Martin and Dr. Catherine Younger-Lewis, address the abuse of women.

Why does this invariably happen? An article about the care of women is published, and someone objects that it appears to exclude men. If a medical journal published an article on a condition affecting children, say gastrointestinal disorders, would letters arrive asking "Why ignore adults? Don't we also suffer from GI disorders?"

The purpose of the article by Martin and Younger-Lewis and the exceptional list was to provide a tool for all physicians to help their patients discuss, and perhaps even address, abusive relationships. Remember the introductory paragraph: "This list is based on one made by *men* [italics mine] who were describing how they controlled or harmed their wives or girlfriends."

I speak as a woman who escaped 15 years ago from a long-term abusive relationship. The Lanark County Interval House list is the best thing I have ever read on abuse. As Martin and Younger-Lewis so eloquently state: "Many of the actions listed may be considered innocent when weighed in isolation. In combination and over a period of time, however, they may constitute a pattern of behaviour designed to break another person's spirit." The list validates the experience of a woman subjected to assaults on her spirit. If this list had been offered to me by my GP or my children's GP, it could have changed my life and given me the courage to leave years earlier.

Pay attention, physicians. This list works. Use it.

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Received by email

Getting prepared for rural practice

Dr. Allon Reddoch's article "A warm place to practice: meeting the challenges of medicine in the North" (*CMAJ* 1998;158[3]:337-8) voices the concerns of many future medical students. Our medical schools must recognize that the shortage of rural practitioners is partly associated with the lack of technical training for rural practice.

I hope to practise as a family physician in a rural or remote setting. I am familiar with the limitations of these practices because I was raised in Faro, YT. My concern is that medical school will not provide me with the technical skills and the knowledge needed to practise in resource-poor regions like the Yukon.

As Reddoch noted, some schools are providing rural rotations, but more universities must recognize the special technical needs of rural physicians. Acknowledging resource limitations and then training physicians