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.

Charles M. Godfrey, MA, MD
Professor Emeritus
University of Toronto
Toronto, Ont.

References

1. McMaster PD, Hudack SS. Induced alterations in the permeability of the lymphatic capillary. *J Exp Med* 1932;56:239-53.
2. Rubin P. Radiation toxicology. *Cancer* 1977;39:729-36.
3. Casley-Smith JR. Endothelial permeability. The passage of particles through the lymphatic endothelium of the normal and injured ears. *Br J Exp Pathol* 1965;46:25-49.
4. Godfrey C. A long-term follow-up treatment of post-mastectomy lymphedema. Royal College of Physicians and Surgeons of Canada meeting; 1996; Halifax.

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.

Robert L. Reid, MD
President
Society of Obstetricians and Gynaecologists of Canada
Department of Obstetrics and Gynaecology
Queen's University
Kingston General Hospital
Kingston, Ont.

Reference

1. Working Group on Breast Cancer and Hormone Replacement Therapy, Society of Obstetricians and Gynaecologists of Canada. Hormone replacement therapy: an update. The benefits of hormone replacement therapy and counselling issues related to breast cancer. *J Soc Obstet Gynaecol Can* 1998;20:490-6.

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-