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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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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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.