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