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 recurrence after excisional biopsy. 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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References

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 colorectal cancer.

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. 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.

The Cancer Genetics Studies Consortium recently published its recommendations for follow-up care of people with an inherited predisposition to breast cancer because of mutant genes. 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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References

[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 Goldrey, 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 patience with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. We probably should have. I have little tolerance with us guidelines writers. 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.

Maurice McGregor, MB, BCh, MD Chair, Steering Committee on Clinical Practice Guidelines for the Care and Treatment of Breast Cancer Professor of Medicine McGill University Montreal, Que.

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]:1555-8) 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 arise asking “Why ignore adults? Don’t we also suffer from GI disorders?”

The purpose of the article by Martin and Younger-Lewis is 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 mea [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.

Jennifer Raiche Gloucester, Ont.

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 practice 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