"the estimated risk of malignancy should be at least 2%." In other words, if the estimated risk is 1%, a biopsy should not be performed, but if the risk is 2%, the procedure should be done. However, it is probably impossible to determine a 1% increment of risk from mammographic results.

- Finally, on page S12 under category 3 abnormalities it is stated that "[i]n the case of a suspected papillary lesion, the patient should also be referred for open surgical biopsy because of the difficulty in pathologically interpreting the core specimen (level V evidence)." This recommendation is not supported by any published literature. It may be true that there are more important lesions that should not undergo core biopsy. Parker and Jobe, the pioneers of breast core biopsy, stated that the only patients for whom they do not routinely request core biopsy are those suspected of having radial scar.[3] They also stated that core biopsy of granular or cotton ball calcifications is controversial because they are a marker of diffuse disease (benign or malignant).

Pasteur Rasuli, MD
Department of Radiology
Ottawa General Hospital
Ottawa, Ont.

References

1. Anderson ED, Muir BB, Walsh JS, Kirkpatrick AE. The efficacy of double reading mammograms in breast screening. *Clin Radiol* 1994;49:248-51.
2. Anttinen I, Pamilo M, Soiva M, Roiha M. Doulbe reading of mammography screening films — one radiologist or two? *Clin Radiol* 1993;48:414-21.
3. Parker SH, Jobe WE. *Percutaneous breast biopsy*. New York: Raven Press; 1993. p. 62-3.

[The chair of the Steering Committee responds:]

On behalf of the Steering Committee I thank these contributors for their suggestions. The following comments are my own.

I do not think that Dr. Leo Mahoney and the Steering Committee disagree, although we have not used the words Mahoney suggests. The guidelines say that "once a lump or *suspicious* change in breast texture is discovered, it is necessary to establish whether it is malignant or not" and "a *clinically suspicious* lump requires further investigation" [emphasis added]. However, "the principle is to establish a reliable diagnosis using the minimum of procedures." We surely should not have recourse to excisional biopsy in the absence of suspicion.

Many of the suggestions made by Dr. Rasuli in his review of an earlier draft of one of the guidelines were incorporated. Some of his points, the remaining problems to which he refers, are valid but debatable and were not incorporated. This situation is inherent in a consensus document. Level V evidence is, by definition, the unsupported opinion of the authors.

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

Updating the insulin lispro file

I suspect that a delay between the time of writing and the date of publication of the article "Insulin lispro (Humalog), the first marketed insulin analogue: indications, contraindications and need for further study" (*CMAJ* 1998;158[4]:506-11), by Drs. Anuradha L. Puttagunta and Ellen L. Toth, may be responsible for the inclusion of only studies published up to 1996. However, more recent studies have addressed a number of the questions raised in that article.

The efficacy of insulin lispro in improving the levels of hemoglobin A_{1c} ($HgbA_{1c}$) has been demonstrated recently; the analogue is particularly effective when the basal insulin and the meal plan are adjusted. Ebeling and associates[1] reported that when

Submitting letters

Letters must be submitted by mail, courier or email, not by fax. They must be signed by all authors and limited to 300 words in length. Letters that refer to articles must be received within 2 months of the publication of the article. *CMAJ* corresponds only with the authors of accepted letters. Letters are subject to editing and abridgement.

Note to email users

Email should be addressed to **pubs@cma.ca** and should indicate "Letter to the editor of *CMAJ*" in the subject line. A signed copy must be sent subsequently to *CMAJ* by fax or regular mail. Accepted letters sent by email appear in the Readers' Forum of *CMA Online* (**www.cma.ca**) promptly, as well as being published in a subsequent issue of the journal.

Pour écrire à la rédaction

Prière de faire parvenir vos lettres par la poste, par messager ou par courrier électronique, et non par télécopieur. Chaque lettre doit porter la signature de tous ses auteurs et avoir au maximum 300 mots. Les lettres se rapportant à un article doivent nous parvenir dans les 2 mois de la publication de l'article en question. Le *JAMC* ne correspond qu'avec les auteurs des lettres acceptées pour publication. Les lettres acceptées seront révisées et pourront être raccourcies.

Aux usagers du courrier électronique

Les messages électroniques doivent être envoyés à l'adresse **pubs@cma.ca**. Veuillez écrire «Lettre à la rédaction du *JAMC*» à la ligne «Subject». Il faut envoyer ensuite, par télécopieur ou par la poste, une lettre signée pour confirmer le message électronique. Une fois une lettre reçue par courrier électronique acceptée pour publication, elle paraîtra dans la chronique «Tribune des lecteurs du *JAMC*» d'*AMC En direct* (**www.cma.ca**) tout de suite, ainsi que dans un numéro prochain du journal.