"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.

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[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

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basal insulin was adjusted to optimize pre-meal glucose levels, administration of insulin lispro led to a significant decline in the level of glycated hemoglobin, from 8.8% to 8.0%, without an increase in the risk of hypoglycemia. Others have also reported significant improvements in levels of $HgbA_{1c}$ (by 0.3% to 0.4%) with insulin lispro and basal insulin adjustments.[2,3] Thus, the concerns raised by the authors about a tendency for "higher fasting and preprandial blood glucose levels with this analogue" and a lack of "differences in the $HgbA_{1c}$ level" have now been addressed.

The question of how the meal plan should be adjusted when insulin lispro is used has also been addressed recently, by Ronnemaa and Viikari,[4] who showed a significant improvement in levels of $HgbA_{1c}$ (by 0.2%) when snacking between meals was reduced.

Quality-of-life issues have now been explored to a greater degree than described in the article, particularly in an extensive paper by Kotsanos and colleagues.[5]

Finally, to mention the use of insulin lispro after meals in a paragraph entitled "Contraindications" is somewhat misleading, given that there is growing evidence that this practice may be a suitable alternative in selected situations.[6–8] In fact, the postprandial use of insulin lispro has recently been approved in Europe.

Loren D. Grossman, MD
Associate Vice-President, Clinical Research
Eli Lilly Canada Inc.
Scarborough, Ont.
Received by email

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[One of the authors responds:]

Yes, a fair number of articles on insulin lispro appeared between the submission and publication of our article. As Dr. Grossman indicates, some of these have dealt with the importance of basal insulin, $HbgA_{1c}$ levels, quality-of-life issues and the optimum time for administration of insulin lispro. Although most studies have not demonstrated efficacy in reducing levels of $HbgA_{1c}$, we too hope that the few studies that do show this effect represent the trend for the future and that other investigations will confirm the result by bringing confounding factors under control. However, the reductions in $HbgA_{1c}$ levels achieved to date have been small, and some of the latest studies involving adjustment of basal insulin[1,2] have not shown an improvement in $HbgA_{1c}$ levels.

Ellen L. Toth, MD
Associate Professor
Division of Endocrinology
Department of Medicine
University of Alberta
Edmonton, Alta.

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In defence of the military

The media in Canada seem to take every opportunity to criticize established authority. Some of their favourite targets include government, big business, doctors and the military.

Now a freelance article in the official publication of the Canadian medical profession has joined the chorus of criticism of Canada's Armed Forces. Michael Oreilly, in his article "MD at centre of Somalia controversy finds peace in Northern Ontario" (*CMAJ* 1998;158[2]:244-5), states, "As [Dr. Barry] Armstrong sees it, the disease of incompetence that led to the Somalia débâcle is winning out: 'It is a running sore in the body of the Canadian Forces that won't heal.' "

Some would question whether peacekeeping should be the primary role for the Canadian Forces. In retrospect, it was a serious mistake to select a frontline assault force, the Canadian Airborne Regiment, for service in an area where the mission was poorly defined. The shooting and torture of Somalis is inexcusable, and it is to Armstrong's credit that he brought this issue to public attention.

However, I think it is inappropriate to attach the label "incompetent" to the entire Armed Forces. When it comes to the business of warfare, our Armed Forces are as good as anyone else's.

Robert Shepherd, MD
Gatineau, Que.