

symbol of medicine. I wish there had been mention of the fact that the winged 2-serpent wand or caduceus belongs to Hermes, the messenger of the gods. It is frequently used wrongly as a symbol of medicine in pharmaceutical advertisements. The staff of Asklepios was put on a new Canadian quarter a year ago and in the newspapers it was erroneously called the caduceus, which illustrates the confusion on the subject.

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Reference

1. Brieger GH. Popular mythology. *CMAJ* 2001; 164(10):1471-2.

Hereditary nonpolyposis colon cancer

I am concerned that the recommendation statement from the Canadian Task Force on Preventive Health Care on colorectal cancer screening¹ did not mention the need to screen people with hereditary nonpolyposis colon cancer for other types of cancer. In some kindreds with hereditary nonpolyposis colon cancer, extracolonic malignancies including endometrial, bladder, stomach and other cancers have been reported.² It is important to mention that other surveillance measures in addition to colonoscopy should be considered for people at risk of developing hereditary nonpolyposis colon cancer;³ the article leaves the false impression that a colonoscopy is the only screening modality required in such kindreds.

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References

1. Colorectal cancer screening: recommendation statement from the Canadian Task Force on Preventive Health Care. *CMAJ* 2001;165(2):206-8.
2. Lindor NM, Greene MH. The concise handbook of family cancer syndromes. *Mayo Familial Cancer Program. J Natl Cancer Inst* 1998;90(14):1039-71.

[One of the authors responds:]

We appreciate Edmond Lemire's comments and agree that people with hereditary nonpolyposis colon cancer have an increased risk of extracolonic malignancies. However, the recently published recommendations from the Canadian Task Force on Preventive Health Care¹ were limited to screening for colorectal cancer in people at average and high risk. Thus, screening for other types of cancer, even in people with hereditary nonpolyposis colon cancer, was beyond the scope of this review.

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References

1. Colorectal cancer screening: recommendation statement from the Canadian Task Force on Preventive Health Care. *CMAJ* 2001;165(2):206-8.

Don't forget anserine bursitis

The article by Jack Taunton and Michael Wilkinson on anterior knee pain¹ covered most conditions seen at sports medicine clinics but omitted one frequently misdiagnosed condition, anserine bursitis, which is rare in athletes.

It is easily recognized in overweight, middle-aged or elderly women with anterior knee pain and well-localized tenderness, sometimes with puffiness, about 5 cm below the knee joint on the medial portion of the anterior tibia.² Osteoarthritis of the knee is often present and distracts from consideration of anserine bursitis. Local injection of corticosteroids gives good relief with confirmation of the diagnosis.³

Harold H. Fireman

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References

1. Taunton JE, Wilkinson M. Rheumatology: 14. Diagnosis and management of anterior knee pain. *CMAJ* 2001;164(11):1595-601.
2. Larsson LG, Baum J. The syndrome of anserine bursitis: an overlooked diagnosis. *Arthritis Rheum* 1985;28:1062-5.

3. Klippel JH, Weyand CM, Wortman R, editors. Anserine bursitis. In: *Primer on rheumatic diseases*. 11th ed. Marietta (GA): Longstreet Press; 1998.

[One of the authors responds:]

Harold Fireman makes a good point regarding pes anserine bursitis in his letter concerning our article.¹ We see this condition in hurdlers, steeplechasers and people who run downhill. If it persists you need to consider a traction stress fracture at the site and order a bone scan. If the bone scan is very hot then you will need a CT scan, as I have seen a few of these go to a completed fracture. For the true bursitis, local injection certainly can be effective and I have had good results with topical 10% diclofenac. The patient needs to work on hamstring stretching and quadriceps-hamstring strengthening.

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Reference

1. Taunton JE, Wilkinson M. Rheumatology: 14. Diagnosis and management of anterior knee pain. *CMAJ* 2001;164(11):1595-601.

Longer waits for breast cancer surgery in Quebec could be good news

Nancy Mayo and colleagues suggest that the waiting time between diagnosis and first surgery for breast cancer increased in Quebec between 1992 and 1998.¹ Although this may be due to the recent reform of health services, an alternative or complementary explanation is that more women are being diagnosed following screening by mammography.

With more screening, the proportion of tumours detected early, when they are small and nonpalpable, should increase. The investigation of such cases often requires several procedures, and the referral process is likely to be associated with delays that would not be