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Breast cancer guidelines

As one of the authors of the Canadian Society of Surgical Oncology consensus statement on sentinel lymph node biopsy for breast cancer,[1] I agree with most of the recommendations put forth by Jacques Cantin and colleagues.[2] However, there are 2 philosophical questions I would like to ask the authors in particular and the readership of *CMAJ* in general.

Cantin and colleagues state that "a surgeon who performs breast cancer surgery infrequently should not perform [sentinel lymph node] biopsy." Should such surgeons be allowed to operate on breast cancers at all? If a surgeon cannot perform a sentinel lymph node biopsy reliably then why do we assume that he or she can safely perform a segmental mastectomy or axillary node dissection, procedures that, in my opinion, are even more complicated? We do not publicly identify such stringent criteria for performing other complex procedures (for which surgical volumes have clearly been shown to affect morbidity and mortality), such as the Whipple procedure for pancreatic cancer and the total mesorectal excision for rectal cancer.

The second question concerns the recommendation that patients "should be informed of … the surgeon's success rate with the procedure." This is reminiscent of the publication of morbidity and mortality rates of US cardiac surgeons on the Internet. Should the recommendation of Cantin and colleagues be broadened to include a surgeon's rate of positive margins with segmental mastectomy and the average number of nodes he or she excises with axillary node dissection?

Sarkis Meterissian
Surgical Oncologist
McGill University Health Centre
Montreal, Que.

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Psychological factors in clinical nutrition

I enjoyed reading the first article in *CMAJ*'s clinical nutrition series.[1] Perhaps this was judged irrelevant in a clin-