

References

1. Lambert CJ Jr, Meydrech EF, Scott-Conner CE. Major hepatic resections: a 10-year experience with emphasis on special problems. *Am J Gastroenterol* 1990;85(7):786-90.
2. Tsukada K, Sakaguchi T, Tomiyama T, Uchida K, Sato Y, Tsubono T, et al. Enhanced hepatic portal blood flow induced by prostaglandin E1 following liver transplantation in pigs. *Surg Today* 1994;24:621-6.
3. Aono T, Sakaguchi T, Nakadaira K, Ohtake M, Muto T. Orally administered prostaglandin E1 derivative can enhance liver regeneration in partially hepatectomized rats. *Biochem Pharmacol* 1993;46(4):767-9.
4. Aono T, Sakaguchi T, Tsukada K, Kurosaki I, Hatakeyama K. Effect of prostaglandin E1 on ammonia concentration in blood of patients with hepatic resection. *Dig Dis Sci* 1996;41(1):126-30.
5. Okumura T, Kanemaki T, Kitade H. Stimulation of glucose incorporation into glycogen by E-series prostaglandins in cultured rat hepatocytes. *Biochim Biophys Acta* 1993;1176(1-2):137-42.
6. Beck PL, McKnight GW, Kelly JK, Wallace JL, Lee SS. Hepatic and gastric cytoprotective effects of long-term prostaglandin E1 administration in cirrhotic rats. *Gastroenterology* 1993;105(4):1483-9.
7. Helling TS, Hacker KA, Kragel PJ, Eisenstein CL. Evidence of cytoprotection by prostaglandin E1 with normothermic hepatic ischemia. *J Surg Res* 1994;56(4):309-13.
8. Livingstone C, MacDonald C, Willett B, Houslay MD. Analysis of the adenylate cyclase signalling system, and alterations induced by culture with insulin, in a novel SV40-DNA-immortalized hepatocyte cell line (P9 cells). *Biochim J* 1994;300(Pt 3):835-42.
9. Adachi T, Nakashima S, Saji S, Nakamura T, Nozama Y. Roles of prostaglandin production and mitogen-activated protein kinase activation in hepatocyte growth factor-mediated rat hepatocyte proliferation. *Hepatology* 1995;21(6):1668-74.

GUIDELINE FOR MANAGING BREAST LUMPS

The editors have stated that they would like to receive and publish comments from readers of the Journal. I would therefore like to comment on the letter concerning a guideline for the management of breast lumps by Mahoney and colleagues (*Can J Surg* 1998;41[6]:476-7).

To issue algorithms or guidelines without the supporting rationale or evidence is not a valid exercise. To understand what is involved in developing guidelines, I would respectfully refer the editors to the methodology of the practice guidelines development cycle.¹ This process is used by the Ontario Cancer Treatment Practice Guidelines Initiative. The purpose of the Initiative is to improve the outcomes for cancer patients, to help practitioners apply the best available research evidence to clinical decisions and to promote responsible use of health care resources. The development of guidelines is clearly a time-consuming iterative process. One might infer, erroneously or not, that a group of interested individuals in the University of Toronto has arrived at a "consensus" over a cup of coffee.

With reference to Mahoney's algorithm on page 477, what is the evidence underpinning the recommendation that a 45-year-old woman with no clinical evidence of breast cancer and no risk factors be subjected to biannual mammography?

The risk of breast cancer increases with age. The Ontario Breast Screening Program provides screening only for women 50 years of age or older. Even for this group of women, the evidence of benefit is sparse, and some would argue that the risk of harm outweighs any putative benefit.

If the editors of the Journal are

looking forward to developing a series of credible guidelines for managing common surgical problems, they must stipulate the methodology to be employed. Like it or not, we are living in an era of evidence-based surgery.

John F. Gately, MA, MB
BChir(Cantab)
 Department of Surgery
 McMaster University
 Hamilton, Ont.

Reference

1. Browman GP, Levine MN, Mohide EA, Hayward RSA, Pritchard KI, Gafni A, et al. The practice guidelines development cycle: a conceptual tool for practice guidelines development and implementation. *J Clin Oncol* 1995;13(2):502-12.

© 1999 Canadian Medical Association

Dr. Leo Mahoney and my colleagues at the University of Toronto in their letter in the December issue of the Journal (*Can J Surg* 1998;41[6]:476-7) outlined their recommended procedure for a family doctor to deal with a breast lump.

Their advice about cysts is reasonable. Having treated 8 patients with a cancer that was in the wall of a cyst or adjacent to a cyst, I can verify that all of them were detected by dark or maroon-coloured blood on aspiration of the cyst or by the persistence of a lump after aspiration. The fluid usually aspirated from a cyst does not need to be sent for cytologic examination as they correctly observe.

However, they fail to mention that the cells from a solid lump should definitely be sent for examination. Pathologists are very accurate in confirming the diagnosis on cytologic examination. It is not good practice to stick a needle into a lump and then discard the cells. The cells in the bar-

rel of that needle will supply a diagnosis. Anyone who aspirates a breast lump should obtain slides and pathological confirmation.

Edward B. Fish, MD
Toronto, Ont.

© 1999 Canadian Medical Association

Dr. Mahoney responds

I and my colleagues wish to reassure Dr. Gately that this guideline is consistent with those that already exist.¹ We have adapted it to the perspective of a primary care physician and focused it to manage any medicolegal concerns related to a delayed diagnosis of breast cancer.²

Even if there are no clinical findings or the woman's breast cyst disappears on aspiration, our 45-year-old patient should have mammography as part of her complete assessment.¹ If the mammogram is normal, as expected, it automatically becomes the baseline for a regular biannual mammographic screening program. For the purpose of simplicity, we chose to recommend it as such, rather than as part of the diagnostic evaluation. Whether the next mammogram should be obtained in 2 years, as recommended by the National Cancer Institute,³ or in 5 years,

as recommended by most world authorities, including the National Cancer Institute of Canada,⁴ is debatable.

Our 45-year-old woman thought she had a palpable lump and was informed and concerned enough to report to her family physician for an examination. Like most Canadian women, she likely obtained her information from media sources originating in the United States, which promote mammographic screening beginning at 40 years of age. In view of her obvious concern about her personal breast health, in our view it was prudent to offer, for her consideration, access to biannual mammography at age 47 years instead of 50 years.

Dr. Fish refers to the fact that most consultant surgeons will aspirate cells from a solid breast lump and send them for cytologic examination. They are well aware of the delays and errors that sometimes occur in the process. At the same time they have the opportunity to arrange for excisional biopsy, which will be necessary to establish an unequivocal diagnosis.

From the standpoint of the family practitioner, however, for whom this guideline was prepared, I and my colleagues believe it is much simpler, easier and safer to refer the patient immediately and directly to a surgeon.

Delay in diagnosis of breast cancer

has become a worrisome cause of medicolegal litigation for both surgeons and family practitioners.² By immediate referral, as recommended in our guideline, the family physician can avoid any such stressful experience.

Leo Mahoney, BA, MD, MS

Department of Surgery
University of Toronto
Toronto, Ont.

References

1. Clinical practice guidelines for the care and treatment of breast cancer. *CMAJ* 1998;158(Suppl 3):S3-4.
2. Osuch JR, Bonham VL. The timely diagnosis of breast cancer. Principles of risk management for primary care practitioners and surgeons. *Cancer* 1994;74(1 Suppl):271-8.
3. National Institutes of Health Consensus Conference on Breast Cancer Screening for Women Ages 40-49. Proceedings. Bethesda, Maryland. January 21-23, 1997 [review]. *J Natl Cancer Inst Monogr* 1997;(22):vii-xviii, 1-156.
4. Morrison BJ. Screening for breast cancer. In: Canadian Task Force on the Periodic Health Examination. *Canadian guide to clinical preventive health care*. Ottawa: Health Canada; 1994. p. 788-95.

© 1999 Canadian Medical Association