

traoperative or postoperative complications. The question of the appropriateness of laparoscopic colectomy in patients with potentially curative cancers is an important one. Palliative resections were performed in just 20% of cases. If an appropriate mesenteric resection or an appropriate isolation of the specimen cannot be accomplished, the operation should be converted. We also "bag" all cancer specimens for removal to avoid tumor implants.

To accurately evaluate laparoscopic colectomy, a standardized, descriptive nomenclature is mandatory when reporting results. To keep better records and compare apples to apples, we propose the following categories of laparoscopic colectomy:

1. Mobilization facilitated colectomy—bowel peritoneal attachments divided, but mesenteric division, resection, and anastomosis performed extracorporeally.
2. Resection facilitated—mobilization and mesenteric and bowel resection performed intracorporeally, but anastomosis performed extracorporeally.
3. Anastomosis facilitated—resection and anastomosis performed intracorporeally, but a small incision is performed to remove the specimen or insert an anvil or anastomosis device.
4. Completely laparoscopic colectomy—resection and anastomosis performed intracorporeally, specimen removed via rectal lumen, or trocar under 30 mm in size.

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Dear Editor:

I read with interest the article by Smith et al., "Evaluation of the Contralateral Breast—the Role of Biopsy at the Time of Treatment of Primary Breast cancer."¹ Early detection of breast cancer has been pursued vigorously by screening programs, including mammograms, biopsy of suspicious lesions, or blind biopsies of the contralateral breast. All these are undertaken to abide by the fundamental principle of cancer management—i.e., that early detection of malignancy leads to a better chance of successful treatment and an improved survival rate.

This principle needs to be re-evaluated in breast cancer. The NSABP Bo-6 randomized trial² of 1843 women with stage I and II invasive breast cancer shows that patients treated by lumpectomy alone had a 40% recurrence rate in the breast. However, the long-term distant disease-free survival and overall survival of patients at 8 years was statistically similar to those treated with initial mastectomy or lumpectomy with radiation. In an Austrian study³ on small tumors, local procedures had no significant impact at a median observation time of 15 years. The "lumpectomy only" arm had a 40% local recurrence-free

survival. Yet, the overall survival rate matched that of the group treated by mastectomy, or lumpectomy and radiation. In both studies, all patients had axillary node dissection. Those with positive nodes were treated with combination chemotherapy.

This author does not recommend the other extreme of "benign neglect" toward breast cancer detection and management. However, a reasonable middle-of-the-road approach to breast screening and treatment may provide the best survival rate in a cost-effective manner. It is time to correlate cost-effective techniques in cancer detection (and their frequency) to survival, as was done a decade ago for pap smears of the cervix.

References

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Dear Editor:

Dr. Lawrence raises several valid issues in his letter. The major focus of our manuscript was that contralateral breast biopsy was not clinically efficacious and therefore, not cost effective. Dr. Lawrence's statement that early detection has led to increased survival is correct. This has been demonstrated by the HIP¹ and the Swedish² studies in women older than 50 years of age.

With regards to local recurrence after breast-conserving surgery, again Dr. Lawrence's statement that local recurrence was not associated with decreased survival is correct. The point to be emphasized, however, is that even if all patients with local recurrence were treated expeditiously (usually with mastectomy) so that overall survival was not negatively impacted on, a psychological and personal trauma (due to subsequent mastectomy) would still accompany the local recurrence. It seems intuitively obvious that no treatment or delayed treatment for local recurrence would negatively impact on survival.

Finally, a "middle-of-the-road" approach to screening for breast cancer, as suggested by Dr. Lawrence, may be the most sensible in view of the impending changes in health care. Screening mammography and breast self-examination, particularly for women older than 50 years of age, will be very important. In younger women, in whom previous studies have failed to show increased survival, screening mammography remains controversial, despite the fact that all professionals involved in the treatment of patients with breast cancer can cite patients