

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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August 25, 1992

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.

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GILBERT LAWRENCE, M.D.
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November 1, 1993

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

whose lives have been saved through this technique. Hopefully, with the use of molecular and genetic markers, careful family history, and judicious screening programs, a cost-effective means of early detection will be achieved.

References

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TIMOTHY J. EBERLEIN, M.D.
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December 3, 1993

Dear Editor:

Drs. O'Rourke and Altmann in their reply to our letter¹ do not address most of the criticisms we directed at their article.²

First, the authors claim that they did not begin estimating tumor thickness until 1982, because Breslow published his article in relation to thickness in 1977. We would like to point out that Breslow first published the importance of thickness as a prognostic indicator in 1970³ and followed this by a confirmation of his findings in 1975.⁴ Also, the authors maintain that because many tumors were excised outside their institution, they were unable to recall all of the relevant slides for review of thickness. By way of comparison, by December 1976, the Sydney Melanoma Unit had successfully recovered nearly 90% of the primary melanoma slides on the 1900 patients in their database, some diagnosed as far back as 1950, and approximately half of which were not excised by surgeons within the Unit. All recalled slides were then reviewed for thickness by the late Professor V. J. McGovern. Indeed, it was common practice for other groups around the world to be measuring thickness by 1980. Furthermore, it is quite incorrect for O'Rourke and Altmann to maintain that Clark's level gives an estimate of thickness. There are so many exceptions to this that today, no one would take this statement seriously.

It is a bizarre notion of O'Rourke and Altmann that patients with tumors greater than 3 mm thick die, and therefore, it is not worth considering a wide local excision for them to reduce local recurrence of disease. This clearly is not true because nearly 60% of our patients with tumors of this thickness survive more than 5 years, thus making this notion not worthy of further comment. These authors suggest a corollary to wide local excisions for high-risk melanoma is that surgeons also should need to resort to "wide radical mastectomy and grafting of the chest wall" for high-risk breast cancer. This analogy is ridiculous because a 2-cm margin excision for a skin melanoma could not seriously be compared with a mastectomy for breast cancer.

The authors make a rather feeble attempt to use sarcasm rather than fact in response to our surprise at their high complication rate of 31%, and this sarcasm reflects rather badly on them. We do not even mention dressings and we make no

claim of 100% take with grafts but certainly their rate of 31% is far higher than most other series. Grafts on the limb should have a negligible non-take rate, and very few surgeons lose such a high proportion of their grafts on the trunk.

Finally, it behooves all authors of scientific articles to check carefully for typographical errors in their manuscripts rather than, as O'Rourke and Altmann suggest, assume that readers will recognize such errors as inevitable and quite irrelevant.

Overall, we maintain our original stance that this article does not support its conclusions and should not have been accepted for publication in its original form.

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HELEN M. SHAW, Ph.D.
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April 28, 1994

Dear Editor:

In regard to Drs. McCarthy's and Shaw's continuing correspondence and their letter of December 3, 1993, I do concede that Breslow's first publication in relation to thickness was in 1970; however, his first publication relating to the thickness in tumor excision was in 1977.

The rest of the first paragraph is irrelevant because what the Sydney Melanoma Unit want to do chasing slides is their own business. However, what is of significance is both tumor thickness and Clark's levels measure the vertical phase of melanoma growth, in other words, the invasive phase. If tumor thickness is more significant, so be it, but it is absurd to dismiss Clark's levels as not being significant in this regard. We point out that it is the vertical phase that is important and that the horizontal phase is of minor relevance and thus, width of excision can be less radical.

To substantiate our argument, at the International Melanoma Conference held in Brisbane from April 6 to April 9, 1994, we presented a further 100 patients, all with invasive melanoma of all thicknesses, who had been followed for from between 2.5 to 5 years, with a mean of 3.75 years. There was a 2% local recurrence rate. These patients had a 1-cm excision margin; these were exactly the same results we had published earlier. Added to this, the discussion in the melanoma workshop by the international delegates from Europe, Asia, North America, and Australasia came to a consensus view that 1 cm was the optimal margin for excision, and I know Dr. McCarthy was at that meeting.