

Nurse-practitioner-led breast clinics

Mr Earnshaw and Ms Stephenson (May 1997 *JRSM*, pp 258–59) report their initial experience of a nurse-led breast follow-up clinic. Their data support the safety of this extension of nursing practice since no clinical recurrence was missed by the nurse. Although they do not provide data on the tumour, nodes and metastases status of their patients, they state that both early and advanced breast cancers were included. However, training of the nurse by the breast surgeon was only in breast examination. This training is certainly appropriate for patients with early breast cancer with a low (1.5% per year) risk of recurrence within the conserved breast per year¹ and where most recurrences are symptomatic. We have reservations about including patients with advanced breast cancer within nurse-led breast cancer follow-up clinics. Most of these patients relapse with metastatic disease². While there is no evidence that early detection and treatment of metastatic breast cancer improves survival, clinical assessment of potential metastatic sites assumes greater importance in locally advanced disease. Our recommendation is that nurse-led breast cancer follow-up clinics be confined to early breast cancer where core skills in breast and peripheral lymphatic examination alone are needed. If the value of a nursing role is confirmed in this setting by randomized trials comparing nurse-led with traditional medical follow-up, more comprehensive training in clinical examination will be needed before consideration of nurse-led follow-up in locally advanced disease.

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Complications of endoscopic sinus surgery

In their very good review article (August 1997 *JRSM*, pp 422–28) Professor Lunt and colleagues mention anaesthesia but say little about its merits and demerits in relation to the medicolegal aspects of this surgery. Our first observation concerns the use of the head-down position and nasal decongestants such as adrenaline 1:1000. In our experience this position tends to increase nasal congestion and contributes to nasal bleeding as a result of increased venous pressure. A more satisfactory strategy is to apply topical cocaine 10% with 1:1000 adrenaline—*after* general anaesthesia has been induced and with full cardiovascular monitoring. Although the toxic side-effects of cocaine are not dose related the use of a disposable metered aerosol device ensures a maximum arbitrary dose of 200 mg cocaine initially; a further 100 mg can be applied by ribbon gauze or cotton wool ball if required (7 squirts=1 mL, 5 squirts per nostril). The safety advantage of general anaesthesia¹ is lost unless halothane is avoided and the choice of volatile anaesthetic agent confined to isoflurane. The dangers of halothane in the presence of cocaine and adrenaline are well established². Isoflurane has a completely different cardiovascular profile from halothane and is remarkably cardio-stable. General anaesthesia appears to provide protection from the patients *endogenous* catecholamines which are the cause of the 3 in 1000 incidence of major cardiovascular collapse reported with use of cocaine in awake patients³. The continuation with adrenaline substantially reduces systemic absorption of the cocaine⁴. In our hands this technique avoids cardiac arrhythmias. Over a 10-year period and in more than 2000 applications only one patient has had a serious arrhythmia—supraventricular tachycardia (SVT). The SVT developed in the recovery ward 40 minutes after the application of cocaine and adrenaline and approximately 10 minutes after awakening from anaesthesia. This arrhythmia responded to treatment including calcium channel blockers. The following day she was admitted to the medical unit with a *Yersinia* septicaemia which subsequent enquiry indicated she had been incubating.

The combination of head-up tilt, topical cocaine and adrenaline and general anaesthesia results in minimal blood loss (approximately 50 mL per patient) even, in some cases, without hypotensive anaes-

thesia. This figure, considerably less than the reported average of 300 mL, is reflected in the quality of the operating field.

Of all surgical procedures endoscopic sinus surgery requires the greatest cooperation between surgeon and anaesthetist. The use of hypotension to facilitate surgery is a balance between the known risks of the surgical technique and potential risks of hypotension. To this end the monitor from the teaching camera of the endoscope can be very useful.

Hypotension is defined in several arbitrary ways. What is not widely appreciated is the fundamental difference between pressures measured directly and those measured indirectly. With the patient in a 15° head-up tilt and the direct arterial blood pressure transducer zeroed against the medulla the difference between the direct and indirect blood pressure reading may be as much as 20 mmHg—once the non-invasive pressure falls below 100 mmHg. Thus a 'mild degree of hypotension' to approximately 85–90 mmHg systolic measured indirectly may in fact be as low as 65 mmHg systolic at the level of the medulla. If hypotension to these pressures is deliberately invoked most experienced anaesthetists would regard invasive monitoring as mandatory.

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Female genital mutilation and Baker Brown

In his article on genital mutilation (July 1997 *JRSM*, pp 402–405) Dr John Black