the original pathology was reviewed by Clark, who verified that the metastasizing thin melanomas initially studied at UCLA had been adequately sampled. These included lesions with evidence of extensive regression. Since that time, metastasizing thin melanomas have been reported by many authors, including Gromet, Woods, Paladugu, Naruns, and Shaw.[5-9] The incidence of metastasis from thin melanomas in these 5 series has been reported as 5.8%, 3%, 22%, 5.5%, and 7.2%, respectively.

In summary, the experience of Hughes represents a substantial series of patients managed in a primary care setting, with excellent outcome after excision of thin melanomas. The experience in a tertiary care referral center in a different part of the world is likely to reflect a different patient population. Hughes suggests that changes in the methods of histologic evaluation may permit a more reliable definition of a "thin" melanoma. This could be an important development, and further evaluation of the histopathologic/clinical correlation is warranted. At present, however, the literature supports the findings that a small but measurable percentage of patients with thin melanomas do develop metastases, and that there are clinical and histologic variables that may assist in identifying the patients at risk.

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December 15, 1988

Dear Editor:

Dr Skinner and his colleagues should be complimented on their excellent study, "Nonpalpable Breast Lesion At Biopsy: A Detailed Analysis of Radiographic Features" (Ann Surg 1988; 208:203). I would only note (at the last paragraph) that among "the simple techniques that may increase the sensitivity and specificity of conventional mammograms," in the case of intracystic cancer, is the insufflation of air (after ultrasonography, paracentesis, and aspiration). In this way, one may see, on a new mammogram, many calcifications that were previously not visible.[1]

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January 12, 1989

Dear Editor:

We appreciate Dr. Sakorafas' comments. The method of insufflating air into the breast to visualize small calcifications takes advantage of the difference in density between gas and calcium. We have no personal experience with this method. What is not known, however, is whether an increase in the sensitivity for discovering small calcifications leads to an increased sensitivity for the diagnosis of breast cancer. In our study, we have shown that the character of mammographic calcifications (i.e., size, clustering, or density) is not helpful in predicting the presence of cancer. It is possible that the nearly microscopic calcifications seen only after the insufflation of air may be likely to be associated with carcinoma. If this is the case, then this may become a very useful technique.

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December 15, 1988

Dear Editor:

Hopman and coworkers[1] have clearly demonstrated that the long-acting analogue of somatostatin—SMS 201-995—is highly effective in the prevention of clinical symptoms related to the dumping syndrome.

However, the exact mechanism of the dumping syndrome following gastric resection is yet unknown, a number of investigations having shown that the release of gastrointestinal hormones plays an important role in the development of the symptoms. The benefit of somatostatin in the dumping syndrome is based theoretically on its hormone-release blocking effect. Hopman and colleagues studied the changes of plasma insulin level only and did not investigate the characteristics of other hormones. But besides insulin, the dynamic parameters of other hormones are also necessary to explain all the signs characteristic of this syndrome.

We investigated eight patients (mean age, 51 years) presenting with the symptoms of early and late dumping syndrome following Billroth II gastric resection.

All of the patients underwent two oral glucose challenges with 75 g of glucose to provoke the dumping symptoms. In double-blind fashion and in random order either 50 μg SMS 201-995 or isotonic sodium chloride was given subcutaneously 15 minutes before the oral intake of glucose. The subjective symptoms of the patients were monitored during the challenges and packed-cell volume, pulse rate, and the plasma levels of vasoactive intestinal polypeptide (VIP), gastric inhibitory peptid (GIP), insulin and blood glucose levels were determined by standard techniques and radioimmunoassay. The results of the two glucose challenges were compared using paired Student's t-tests.

With placebo all patients experienced the subjective symptoms (weakness, epigastric distress, fainting, palpitation) of the early dumping syndrome. In this study significant increases were detected (initial levels and maximum changes; mean $\pm$ SD) in pulse rate (from 66 $\pm$ 8, to 102 $\pm$ 10 beats/min), in packed-cell volume (from 0.36 $\pm$ 0.05 to 0.43 $\pm$ 0.1 1/1), and in the plasma level of VIP (3.0 $\pm$ 0.5 to 10.2 $\pm$ 1.8 pmol/1).