results comparable to and in some ways superior to more traditional forms of care (W D Savage and R M Cochrane, Nivel international conference on primary care obstetrics and perinatal health, s'Hertogenbosch, 1991). We accept that such a scheme, in which hospital specialists visit local surgeries during their antenatal clinics and in which women therefore need not attend hospital at all, would be inappropriate in some areas. Nevertheless, some may wish to emulate the idea for the benefits outlined above and for the fruitful interprofessional respect that such care engenders.

WENDY SAVAGE
RUTH COCHRANE
SIVA PATHASUNDARAM

Academic Department of General Practice and Primary Care, Medical Colleges of St Bartholomew's and The London Hospitals, London EC1M 6BO

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Reporting of fine needle aspiration

SIR,—We have three years' experience with fine needle aspiration at a weekly surgical breast clinic. We would agree with Mr J Michael Dixon that the method is accurate, and prompt reporting allows repeat aspirations if the material initially obtained is inadequate. It reduces the patient's anxiety and avoids unnecessary return outpatient visits.

There are many additional advantages not mentioned by Mr Dixon. Fine needle aspiration is a cost effective technique. It facilitates education of junior surgeons in aspiration technique as the cytopathologist provides immediate feedback as to the adequacy of material obtained and will, if required, demonstrate the correct technique of aspiration and preparation of material.

A trained counsellor is in attendance and can provide immediate counselling to patients with suspicious or malignant lesions. The presence of a cytopathologist at the clinic provides a useful opportunity for discussion of difficult cases. The aspiration can be performed by either the surgeon or the cytopathologist and this allows a speedier throughput of patients. In general, however, the surgeon will perform the aspiration.

We disagree with the statement that a "technician and an experienced cytopathologist have to be available to stain and report the findings." With the Diff Quik stain both staining and reporting are easily done by a cytopathologist.

Mr Dixon wonders why the system is not more widely used in Britain. The technique is time consuming, requiring the cytopathologist to attend at the surgical clinic for several hours each week. There is at present a shortage of experienced cytopathologists, and heavy routine work commitments in the laboratory prevent many from being available to provide what is undoubtedly a valuable service.

MARIA NAYAGAM
JOAN M McCUTCHEON
A E YOUNG

St Thomas's Hospital, London SE1 7EH

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Diagnosing breast carcinoma in young women

SIR,—Based on a 19 year review of the diagnosis of breast carcinoma in young women, Dr A Yelland and colleagues seem to recommend that all discrete lumps in young women should be excised.[1] Diagnostic techniques have clearly improved over recent years and conclusions from this review must be questioned.

The authors have confirmed our previously published findings that clinical examination and mammography have a low sensitivity for detecting breast cancer in young women.[2] Although they indicate that ultrasonography has been used in their centre, they do not present any results for this investigation, which is disappointing as this investigation is clearly useful in young women, in whom the sensitivity of mammography is low.[3]

Of greatest concern, however, are their results for fine needle aspiration cytology. We have looked at the factors influencing the accuracy of fine needle aspiration cytology and have not found age to be an important factor.[2,4] It is clear from our results that the accuracy of fine needle aspiration cytology has increased significantly over the past decade. Of the last 30 women with palpable breast cancer under the age of 36 years treated in our unit over the past three and a half years, all had fine needle aspiration and the findings reported as malignant in 27, suspicious in two, and acellular in one. If the unsatisfactory specimen is included then this gives a sensitivity for fine needle aspiration cytology of 97%. Sensitivity is usually calculated after excluding unsatisfactory aspirates, and if this is done the sensitivity for breast cancer in young women treated in our unit is 100% (compared with 78% reported by the group at St George's). These results are similar to those published recently by the group from Southampton.[3] It would be important to know what the results of cytology were over the past five years in the unit at St George's. If they are similar to our own and those of the Southampton group then the whole message of the paper by Dr Yelland and colleagues is undermined.

Our current management in young women with clinically benign breast lumps is to perform a fine needle aspirate on all women. If the fine needle aspirate confirms that the lesion is benign then the patient is reviewed. Most patients who have discrete lumpy areas are usually then reassured and discharged, and an unnecessary biopsy is avoided. This approach has been shown to be safe.[5] Patients who have a clinical and cytological diagnosis of a fibroadenoma are offered the opportunity of having their lump removed under local anaesthesia or of keeping the lump under observation. Those patients who elect to keep their lump then undergo an ultrasound examination, which allows confirmation of the benign nature of the lesion and measurement of its size. The lesions are then scanned at three months, six months, and one year as we are currently monitoring the course of fibroadenomas. Increase in size is an indication for excision, but as yet we have not identified any patient whose lump has got bigger and therefore had to be excised. Over 90% of patients are currently opting for observation only, and this figure is similar to that reported in a study from Oxford.[5] The view that young women with breast lumps wish to have them excised is therefore clearly incorrect.

J MICHAEL DIXON

Royal Infirmary, Edinburgh EH3 9YW

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AUTHORS' REPLY,—We compliment Mr J Michael Dixon and his colleagues on the extreme accuracy of diagnosis of cancer of the breast in patients under 36 in a small series of 30 patients. However, we would respectfully draw his attention again to the last paragraph of our paper, which states: "We suggest that centres not possessing adequate cytological and combined mammographic facilities should excise all discrete breast masses in this age group without previous investigation. We also suggest that the poor detection rate by general practitioners warrants all young patients presenting with a breast lump being referred to a surgeon with an interest in breast disease."[1]

We think that it is a matter for discussion as to whether one can safely leave a presumed fibroadenoma in the breast with the added anxiety of repeated assessment and evaluation. We agree that most patients who have discrete lumpy areas can usually be reassured after evaluation. However, we were discussing a discrete mass. The workload of long term follow up in our unit would become prohibitive.

Finally, a 100% accuracy in diagnosing carcinoma by cytological, radiological, and clinical means is a laudable aim but, in our opinion, is rarely achieved.

R C COOMBES
H T FORD
J-C GAZET

St George's Hospital, London SW17 0QT

1 Yelland A, Graham MD, Trott PA. Diagnosing breast carcinoma in young women. *BMJ* 1991;**302**:618-20. (16 March.)

Compensation for medical accidents

SIR,—The article by Mr Brian Capstick and colleagues on compensation for medical accidents raises a number of interesting issues—dealth with, adequately I believe, by my NHS (Compensation) Bill. He raises the problem of causation. It has been asserted by those opposed to the introduction of a no fault scheme that victims of medical accidents have as much difficulty in establishing causation as they do in proving negligence. As a result, they argue, no fault compensation will not assist them as they will still be required to prove a causal link between medical care received and resulting injury. I, and all those who supported my bill, dispute this. Unless one introduces a general disability compensation scheme, compensating individuals on the basis of need and not on the basis of how they acquired their disability, there will always be a need to prove causation. There will always be some worthy cases that do not qualify. The main hurdle under the present tort based system is the need to prove negligence. Many injuries result from "reasonable" care. They deserve compensation. My bill would have ensured that.

My bill would not have resulted in a flood of trivial claims or a massive increase in costs. The 1948 Law Reform (Personal Injuries) Act would have been amended to ensure that when awarding damages a court could have taken into account the availability of NHS care rather than having to base an award on provision of private care. The bill also provided for periodic payments of awards. The Medical Injury Compensation Board established