should have a full urodynamic investigation before having any kind of surgical repair.

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Minerva's comment was not evidence based

EDITOR,—Minerva states that, for conservative treatment of breast cancer, tumours of over 3.5 cm and age over 70 are absolute contra-indications.[1] We disagree. Four randomised clinical trials that included 3197 patients have consistently shown that breast conservation is as safe as mastectomy for breast cancers up to 4 cm and even 5 cm provided that a clear surgical margin is obtained and patients receive postoperative radiotherapy to the breast.[2] With regard to age, to our knowledge there are no data that prove that old age would be an independent unfavourable prognostic factor for breast saving procedures. On the contrary, local recurrence may be much lower in this age group than in younger women.[3] Moreover, older women wish to retain their physical integrity as much as young patients do.[4]

It is a pity that, at a time when evidence based decision making is gaining acceptance, Minerva should uncritically mention a conclusion without a good scientific basis.

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1 Minerva. *BMJ* 1996;312: 648. (9 March.)
2 Jacobson JA, Danforth DN, Cowan KH. Ten-year results of a comparison of conservation with mastectomy in the treatment of stage I and II breast cancer. *N Engl J Med* 1995;332:907-11.
3 Veronesi U, Bonfi A, Salvadori B. Breast conservation is the treatment of choice in small breast cancer: long-term results of a randomised trial. *Eur J Cancer* 1990;26:668-70.
4 Monfardini S. What do we know on variables influencing clinical decision making in elderly cancer patients? *Eur J Cancer* 1996;32A:12-4.

Reservations about conservative surgery for early breast cancer are unjustified

EDITOR,—E A Benson suggests that tumours over 2 cm in size should not be treated by breast conservation surgery because they seem to be associated with an increased risk of local recurrence.[1] To support this Benson reports data from Nottingham.[2]

In a comprehensive review of factors affecting local recurrence after breast conservation (wide excision and quadrantectomy and postoperative radiotherapy) we have identified 28 publications that have correlated tumour size and local recurrence. In 25 there seems to be no relation between tumour size and the risk of local relapse. Even in the Nottingham study the actuarial recurrence curves for tumours less than or greater than 2 cm approach each other at eight years, which suggests that with increased follow up the difference in local recurrence rates between these two groups may not be substantiated. The message from the literature is clear: the size of a tumour is not related to the risk of local recurrence. There is thus no scientific basis for Benson's concern about performing breast conservation surgery for tumours larger than 2 cm.

Benson is correct in pointing out that, regardless of tumour size, it is important to ensure that the margins of excision are clear. While other factors such as lymphatic and vascular invasion and tumour grade have been reported consistently to be associated with local recurrence after breast conservation, they are qualitatively less important than obtaining clear resection margins.[3]

Benson indicates that all patients having breast conservation surgery should have a level II or III axillary dissection. The problem with this is that the lymph nodes will be involved in less than a tenth of patients who have impalpable cancers, and to submit all these patients to a full level II or level III axillary dissection seems excessive. A less didactic and more flexible policy of managing the axilla was outlined in the ABC of Breast Diseases[4] and reflects not only our current practice but, we believe, current best practice.

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1 Benson EA. Reservations about conservative surgery for early breast cancer. *BMJ* 1996;312:845-6. (30 March.)
2 Locker AP, Ellis IO, Morgan DAL, Elston CW, Mitchell A, Blamey RW. Factors influencing local recurrence after excision and radiotherapy for primary breast cancer. *Br J Surg* 1989;76:890-4.
3 Sainsbury JRC, Anderson TJ, Morgan DAL, Dixon JM. ABC of breast diseases: breast cancer. *BMJ* 1994;309:1150-3.
4 Bundred NJ, Morgan DAL, Dixon JM. ABC of breast diseases: management of regional nodes in breast cancer. *BMJ* 1994;309:1222-5.

Centres that work with cochlear implants listen to views of deaf community

EDITOR,—Rupert Gauntlett points out that a congenitally deaf child given a cochlear implant may not develop normal speech and so may not thrive in a mainstream school.[1] He also emphasises the importance of sign language and "the vibrant culture of deaf people" in allowing congenitally deaf children to acquire language and mentions the opposition of some congenitally deaf adults to implantation for children. Our editorial on cochlear implantation[2] was designed to draw attention to the Medical Research Council's recent report on the national cochlear implant programme in Britain.[3] In the space available we had to limit our remarks to the chief findings of this report, so we were unable to cover many other important issues.

The issue of cochlear implants for congenitally deaf people has been approached cautiously in Britain. Studies quoted in our editorial, however, suggest that there is a place for early implantation in suitable children who are congenitally profoundly deaf. While such children given an implant at around the age of 2 have the best chance of developing normal language and speech, not all will do so. The question of signing needs to be considered seriously for all these children, either as an alternative to implantation or to complement the child's developing oral skills. A child in whom an implant is successful can hear only when wearing the implant's speech processor, and many families believe that their child will benefit from being "bilingual" and thus able to communicate with both hearing peers and those who use sign language to communicate.

The Medical Research Council's report emphasises the need for work with cochlear implants to be performed in "properly founded" multidisciplinary centres. These centres are well aware of the views that have, in the past, been expressed by some members of the signing community; they are particularly keen to maintain links and continue a dialogue with this community and with the British Deaf Association, which represents many of them.

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1 Gauntlett R. Cochlear implantation is controversial among deaf people. *BMJ* 1996;312:850. (30 March.)
2 Ramsden R, Graham J. Cochlear implantation. *BMJ* 1995;311:1588. (16 December.)
3 Summerfield AQ, Marshall DH. *Cochlear implantation in the UK 1990-1994. Report to the MRC Institute of Hearing Research on the evaluation of the national cochlear implant programme.* London: HMSO, 1995.

Evidence used to formulate guidelines on managing asthma did not include costs

EDITOR,—Though we applaud the efforts that went into the project to develop evidence based guidelines for primary care management of asthma in adults, we think that the results need to be handled more carefully.[1] There is category I evidence (as defined by the guideline development group) to show that dry powder devices are more effective than metered dose inhalers.[2 3] Both of the studies providing this evidence show significant improvements in respiratory function, although they were conducted over relatively short periods. There is also good evidence from studies in other chronic respiratory diseases that dry powder devices are significantly easier to use than metered dose inhalers.[4]

Evidence based decision making is becoming a popular concept in health care.[5] It will be useful, however, only if the quality of the evidence is improved, appropriate systems are in place to audit the evidence, the evidence is timely, and all health care professionals have the appropriate skills to decide on using the evidence.

To help advance the debate on the care of asthma we are undertaking a one year randomised controlled trial of the cost effectiveness of different inhaler devices in a primary care setting. Our study will identify and measure various factors, such as clinical outcomes, quality of life (with the short form 36 and St George's Hospital respiratory questionnaire), costs of care, and care processes. The fundamental question relates to the costs and effects of the health care intervention; this question is not unique to asthma or even Britain. Our trial will also answer subsidiary questions, such as how good the questionnaires about quality of life are in capturing outcomes.

If evidence based guidelines are to be cost effective then all the evidence must be considered. If guidelines exclude part of the detail—for example, considerations of costs—then they must take this into account. Thus the first part of the development group's recommendations about drug delivery devices should read: "Health care professionals advising patients should recommend a device that the patients can use and comply with effectively, and in most cases this will be a dry powder device." We do not yet have the evidence to know at what level of prescribing costs a dry powder device stops being the most cost effective treatment.