Blood transfusion does not have an adverse effect on survival after operation for colorectal cancer

I wholeheartedly agree with the last sentence of the abstract of the above paper by Sene *et al.* (*Annals*, July 1993, vol 75, p261) as I am sure do the majority of surgeons dealing with this common disease. However, the assessor, in his invited comment, suggests that despite the use of powerful statistical methods, there may be a "small but perhaps clinically relevant" effect of blood transfusion. I suspect if there is one, it is very small indeed, but I wonder if it is of any real clinical significance.

The vexing question concerning the use of blood transfusions and the ultimate prognosis of patients undergoing colorectal cancer surgery has probably been finally addressed in a recently published Dutch multicentre study *(1)*. In that study patients were randomised to either receive an autologous or allogeneic blood transfusion. Among 423 patients undergoing potentially curative surgery, there was no significant difference in the 4-year disease-free survival of patients given autologous blood (63%) compared with that in patients given allogeneic blood (66%). Furthermore, the authors remarked that survival was probably related to the circumstances which necessitated the transfusion. This situation is certainly of clinical relevance; patients with bulky and locally advanced disease may be anaemic before surgery and the operation may be bloodier if one strives to achieve a curative resection.

B M Stephenson MS FRCS
Senior Surgical Registrar
Cardiff Royal Infirmary

Reference

1 Busch ORC, Hop WCJ, Hoynck van Papdrecht MAW, Marquet RL, Jeekel J. Blood transfusions and prognosis in colorectal cancer. *N Engl J Med* 1993; **328**: 1372–6.

Provision and acceptability of day case breast biopsy: an audit of current practice

The authors of the above article (*Annals*, July 1993, vol 75, p281) report that 83% of the breast biopsies they perform under general anaesthesia are performed as day case procedures. Most breast biopsies (whether benign or malignant) can be performed under local anaesthesia as is standard practice in the USA, Scandinavia and in many units in the UK. Local anaesthetic breast biopsy is not only acceptable to patients but more cost-effective than general anaesthesia *(1)*. Furthermore, the use of radial incisions which give a poorer cosmetic result than incisions along Langer's lines *(2)* and the use of staples and interrupted sutures to close skin when subcuticular absorbable sutures give better cosmetic results *(3,4)* can no longer be justified.

The commentary by Mr Gazet on this paper also concerned us; he incorrectly states that all benign lesions should be excised and is at odds with the practice of most specialist units in this country. It is clear that the majority of patients with benign lesions do not wish to have them excised *(5,6)*. Furthermore, such biopsies are not without morbidity *(7)*. Mr Gazet's suggestion that biopsy or definitive surgery for patients who present with breast lumps should be performed within 48 h of presentation is puzzling as it is clear that the psychological morbidity which occurs in patients diagnosed as having breast cancer is significantly reduced by offering them choices in treatment where these exist *(8)*. Is 48 h really sufficient time to appropriately stage patients, to counsel and support them and thereafter to discuss options decisions about treatment?

J Michael Dixon FRCS FRCSEd
Senior Lecturer in Surgery
A M Thompson FRCSEd
Lecturer in Surgery
Royal Infirmary
Edinburgh

References

1 Chetty U, Nixon SJ, Steele RJC, Forrest APM. Comparison between general and local anaesthesia for biopsy of breast lumps: a randomised study. *J R Coll Surg Edinb* 1983; **28**: 14–16.

2 NIH Consensus Conference 1991. Treatment of early-stage breast cancer. *JAMA* 1991; **265**: 391–3.

3 Goulbourne IA, Nixon SJ, Naylor AR, Varma JS. Comparison of polyglactin 910 and nylon in skin closure. *Br J Surg* 1988; **75**: 586.

4 Johnstone AJ, John TG, Thompson AM, Charles MH, Dixon JM. PDS II® (polydioxanone) is the monofilament suture of choice for subcuticular wound closure following breast biopsy. *J R Coll Surg Edinb* 1992; **37**: 94–6.

5 Dixon JM, Clarke PJ, Crucioli V, Dehn TCB, Lee ECG, Greenall MJ. Reduction in the biopsy rate in benign breast disease using fine needle aspiration cytology with immediate reporting. *Br J Surg* 1987; **74**: 1014–16.

6 Dobie V, Dixon JM, Walsh J. Natural history of fibroadenoma of the breast. In: Mansel RE, ed. *Proceedings of 5th International Benign Breast Disease Symposium* 1993 (in press).

7 Dixon JM, John TG. Morbidity after breast biopsy for benign disease in a screened population. *Lancet* 1992; **339**: 128.

8 Fallowfield LJ, Hall A. Psychosocial and sexual impact on diagnosis and treatment of breast cancer. In: Stewart HJ, Anderson TJ, Forrest APM, eds. Breast Diseases: New Approaches. *Br Med Bull* 1991; **47**: 388–99.

Having enjoyed the article by Mr Coady and colleagues (*Annals*, July 1993, vol 75, p 281) supporting day case surgery for breast biopsy patients, I was surprised to read the 'Invited comment' which barely touches on the substance of the article.

Instead, Mr Gazet chooses to write on the organisation of a breast service and on supervision of SHOs performing day surgery. The ratio of benign to malignant biopsies reported in the article is surprisingly high, but the data are already over 2 years old and the authors stress that steps are being taken to improve this. There is nothing else in the article to justify the criticism of the overall management of these patients implicit in Mr Gazet's comments. Nor is there any reason to suppose that the SHOs at Leeds General Infirmary were operating without supervision.

Mr Gazet advocates performing frozen sections and detaining in hospital those with positive results. Many British readers will envy the facilities which allow him to schedule definitive surgery within 48 h. However, it is possible that some patients would prefer full discussion at an early outpatient appointment with the opportunity to agree upon a convenient date for any further surgery.

A surgeon who treats breast conditions must have the interest and motivation to remain expert in a major field of complex and evolving knowledge and to communicate carefully considered advice to individual patients who may be very anxious about their plight. The quality of such a service must be evaluated in