The authors debate the time before symptoms return. Using my technique the interval was 2 years or more and re-dilatation was not difficult.

G R SEWARD CBE FRCS FDSRCS
*Professor of Oral and Maxillofacial Surgery*
Meyrick Park
Bournemouth

## Should all patients with ureteric colic be admitted?

We read with interest the article on management of ureteric colic without admission (*Annals*, November 1995, vol 77, p450) by Morris *et al.* It is encouraging to read published research regarding such a policy. However, we would like to point out that this is hardly a new idea. General practitioners have been managing ureteric colic in the community for many years. It is not stated in the article whether patients attending the accident and emergency department had been seen by or received analgesia from their general practitioner; in fact no reference was made in the article to the involvement of primary medical care. In our area both local district general hospitals admit approximately 100 patients with ureteric colic per year (population covered by each is approximately 250 000) (personal communications). This would equate to slightly less than one admission for every general practitioner per year. Morbidity statistics from national and local data suggest that a further 200 patients with ureteric colic are managed by the general practitioners in our area without the need for acute admission. This would support the findings in part one of the study that 64% of uncomplicated patients with ureteric colic required no further analgesia after initial management.

We follow a similar management plan for analgesic control and admission and were pleased to see social reasons included as a genuine indication for admission. Recognising the diagnostic dilemma between clinical and radiological diagnosis, further investigations including intravenous urogram are arranged by the general practitioner at a later stage.

We wonder how many of our consultant colleagues are aware just how much ureteric colic is being managed in the community?

RACHEL BISHOP MRCGP
*GP Registrar*
ALISON EVANS FRCGP
*Senior Lecturer in General Practice, Leeds University*
STEPHEN HOLMES, MRCGP
*General Practitioner*
The Surgery
Earby, Lancashire

## Benign breast surgery: is there a need for outpatient follow-up?

We have read the above paper by Wakefield and Powis (*Annals*, November 1995, vol 77, p457) with considerable interest. Any developments which reduce the number of outpatient attendances are to be welcomed both by patients and hospitals. We do, however, have a number of concerns with their study.

They describe overall a benign-to-malignant ratio of 33:1, in stark contrast to other reports indicating a benign-to-malignant ratio of 4:1 for women in a similar age group (*1*). This heterogeneous group of patients actually contained two separate groups of patients. One is a group of patients in whom the operation is being performed for diagnostic purposes to exclude malignancy, and it is not really true to say that these were operations for benign disease. The second group of patients know that a preoperative diagnosis of benign condition has been made on the basis of cytological, clinical and mammographic findings. In this group the procedure is being performed as treatment of a pre-established diagnosis so that the histology in these cases only confirms the accuracy of the other tests. In this group of patients a subsequent diagnosis of cancer should be very rare. A follow-up would not be required for information regarding histology. It is impossible to gauge from the information given in the paper the relative size of these two separate populations.

As a more general comment, some of the biopsies could probably have been prevented by the addition of ultrasound to the preoperative management programme. Indeed the screening programme shows us how, with a combination of clinical examination, cytology and imaging, it is possible to achieve a benign-to-malignant ratio of 0.4:1 (*2*).

Finally, we wonder whether there really is a distinction between fibrocystic disease, fibroadenosis and normal breast tissue which now are more generally brought together under the heading of ANDI (*3*).

S A HARRIES MS FRCS
*Lecturer in Surgery*
ROBERT E MANSEL MS FRCS
*Professor of Surgery*
D J T WEBSTER FRCS
*Senior Lecturer in Surgery and Dean of Clinical Studies*
University of Wales College of Medicine
Cardiff

### References

*1* Socioeconomic variation in admission for diseases of female genital tract and breast in a national cohort aged 15–43. *Br Med J* 1995; 311: 840–43.
*2* *NHS Breast Screening Programme Review*, 1995.
*3* *Benign Breast Disease* Hughes LE, Webster DJT & Mansel RE.

### *Authors' reply*

We are grateful to Mr Harries and his colleagues for their interest in our paper and would like to respond to the points raised in their letter.

As stated in our paper, the study related only to patients undergoing surgery for breast swellings assessed in outpatients as benign. During the same period of time, 128 patients with breast cancer were seen in the Symptomatic Clinic and the benign-to-malignant ratio is, therefore, not the 33:1 stated by Harries *et al.* but 0.74:1. This was not mentioned in the article as it was not relevant to the follow-up of benign breast disease.

Harries *et al.* state that our group of patients was heterogeneous and implies that some of the patients were undergoing surgery for diagnostic purposes and others for operation on benign disease. This is not the case for, as clearly stated, all patients had been assessed in the clinic by appropriate modalities and were presumed to have benign disease and this indeed was the case in 97%. The three cancers occurred in patients under the age of 40 years in whom clinical features were of benign disease and in two of whom cytology failed to confirm the diagnosis.