Authors' reply

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We are sympathetic with Plaut's concerns expressed in response to our article on the management of breast disease.[1] Unfortunately, the diagnosis of breast cancer is not always straightforward, and diagnoses are missed both in primary and secondary care. There are also practical constraints in that specialist breast clinics could not cope with the demand if all women with breast symptoms were referred to them. In a companion study in general practice, we have shown that GPs in Sheffield refer approximately one-third of their women presenting with breast symptoms.[2] They are content to manage the remaining proportion of women, although it is assumed that they will subsequently make a referral if the woman's symptoms remain a source of concern either to the doctor or to the woman herself. Indeed, the study showed that our sample of GPs indicated 'patient pressure' as a strong indication for a referral, and we would strongly advocate referral under these circumstances.

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Letter to the Editor

Council election

A Richard Maw

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During the last two years, the 'single transferable vote system' has been used for Council elections. I have been informed that, had the old 'first past the post' system been used, I would have been elected to Council in the recent election; but, following transfer of votes, I was not elected.

I appreciate that the College has attempted to ensure that the numerically smaller specialties are appropriately represented on Council. However, it appears that the single transferable voting system discriminates against smaller specialties. In all elections to Council there will be more candidates from the larger specialties such as surgery and orthopaedics. As a consequence, more votes will be cast for candidates in these specialties. As the transfer of votes takes place, these will benefit progressively while smaller specialties will be disadvantaged.

Otolaryngology remains under-represented on Council and it appears that at a stroke with this change in the voting system, Council has undone all of their efforts to ensure appropriate representation for smaller specialties.

May I through your columns request that Council give consideration to a review of this electoral system? Whilst it may be intrinsically fair to some, it has on this occasion not only prevented my election to Council, but it has maintained the under-representation of my specialty. I feel personally saddened, but considerably more aggrieved for otolaryngology.

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Response

RJ Heald

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Mr Maw's point is well taken. As one of the people on Council who championed the concept of the single transferable vote, I would, however, suggest that this is not the reason for the under-representation of smaller specialities.

For some years, the splitting of the votes for a small number of prominent and popular urologists resulted in their being no urologist on Council after the retirement of Prof. Blandy. Careful research conducted with the help of the Electoral Reform Society led us to believe that the single transferable vote (STV) was the best way of avoiding such anomalies. With the 'first past the post' system, the splitting of the vote of a small group between two or three popular candidates often means that none of those can compete with a strong candidate from the larger specialties. The general idea with STV is

that, for example, the ENT surgeons would put their favourite ENT people in order and, as one dropped out, so all the votes would be transferred to the others, and ultimately to one. The Electoral Reform Society confirms that these concepts are correct and I would consider it a retrograde step to change the system at this stage.

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Response to paper by PSGF Hardee and IL Hutchison on:

Solitary nodal metastasis presenting as branchial cysts: a diagnostic pitfall

Ann R Coll Surg Engl 1999: **81**; 296–8

Letter 1

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I read with great interest the case report by Hardee and Hutchison. However, there are other diagnostic pitfalls to cystic lumps in the neck, with the clinical appearance of a branchial cyst, which clinicians should also be aware of.

While an FNA may aid diagnosis, it has been reported that branchial cysts if inflamed can show both cellular and nuclear pleomorphism when FNA examination has been undertaken, such that the appearances can be mistaken for a well-differentiated squamous cell carcinoma.[1] The cytological appearances of an FNA sample may require interpretation by an experienced cytologist, because the differences between metastatic squamous cell carcinoma and inflamed branchial cyst can be subtle and relate to the appearances of the nuclear outline and hyperchromatism.[2] Any uncertainty requires careful examination of the aerodigestive tract as highlighted by the authors.

Further pitfalls in diagnosis are possible, since the differential diagnosis of a cystic neck lump may be wider than branchial cyst or metastatic squamous cell carcinoma. Another possible diagnosis in these cases is the rare primary branchial cell carcinoma,[3] which, to complicate matters further (if FNA is used to aid diagnosis), has also been reported occasionally to occur as *in situ* carcinoma.[4]

Clearly, I am in complete agreement with the authors that the correct diagnosis in the subsequent management of cystic neck lumps is very important. However, in these types of cases the results of FNA may require careful interpretation, as false positive (as well as false negative) results are possible.

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Letter 2

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I read this paper with interest. It highlights a diagnostic pitfall with some disastrous consequences.[1] A review of 35 patients presenting with a solitary cervical node to the Head and Neck Unit at the Royal Marsden Hospital had a diagnosis of branchial cyst in seven cases made in other institutions before referral.[2] As pointed out by Hardee and Hutchison, these cases had a history of a cystic swellings at the arterial border of the sternomastoid muscle which were aspirated to reveal straw-coloured fluid, and the diagnosis of branchial cysts was made. Two of these patients had a diagnosis of branchiogenic carcinoma when microscopy revealed atypical cells present in the aspirate. They subsequently had a course of treatment for the branchiogenic carcinoma. Both patients subsequently presented with carcinoma of the aerodigestive tract; one with a tonsilar tumour and the other with a tumour of the tongue base. Hardee and Hutchison have highlighted a problem that, if misdiagnosed, has a significant impact on patient morbidity and mortality. It is logical that, if a branchial cyst is a relatively uncommon anomaly, then branchiogenic carcinoma is extremely rare. Therefore, the diagnosis of branchial cyst and especially branchiogenic carcinoma in an adult should be a diagnosis of exclusion only after panendoscopy and examination under anaesthesia of the aerodigestive tract.