I congratulate the doctors for the excellent results they achieved with their "totally laparoscopic preperitoneal approach." If compared with reports from other centers, they become truly "extraordinary." Nevertheless, in 750 operations, the doctors experienced one unnecessary and potentially fatal case of pulmonary embolism, a complication unheard of with open tension-free repair under local anesthesia. They were required to perform 750 cases of unnecessary general anesthesia, and they generated probably one-quarter to one-half million dollars of unnecessary cost. Weighing these deterrents associated with laparoscopic repair against the documented success, safety, and cost-effectiveness of the open tension-free repair method, the superiority of the latter is clear.

Finally, to make such a statement, I do not feel it necessary to invest our time, our healthcare financial resources, or most importantly, our patient's well-being to do as Drs. Voeller and Mangiante suggest and "develop an effective long-term experience" with what already has been shown to be a less effective, more costly and risky surgical approach. In our view, a comparison of my colleagues' outcomes with the worldwide reported results of open tension-free hernia repair speaks for itself.

References

1. Amid PK, Shulman AG, Lichtenstein IL, Hakakha M. The goals of modern hernia surgery: how to achieve them, open or laparoscopic repair? Prob Gen Surg 1995; 12:165–171.
2. Gilbert AI, Graham MF. Technical and scientific objections to laparoscopic herniorrhaphy. Prob Gen Sur 1995; 12:209–214.

PARVIZ K. AMID, M.D., F.A.C.S.
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June 24, 1996

Dear Editor:

I read with interest the article by Yim et al.[1] describing their experience with stereotactic needle core biopsy. My experience with this diagnostic modality has been less than satisfactory for several important reasons, none of which were discussed in these papers. I would be interested in the authors' insight into these problems.

First, the specimen obtained by needle core biopsy can provide accurately a diagnosis of malignancy (or rule it out), but the specimen may not demonstrate key morphologic features of the tumor that may impact on the patient's decision of which operation is desired for definitive treatment. Although many academic surgeons advocate lumpectomy and radiation for virtually any breast cancer, I have found that most patients with a comedocarcinoma, central necrosis, and an extensive intraductal component suggesting multifocality are unwilling to accept the increased risk of having an ipsilateral metachronous malignant lesion, especially when their number one priority is getting rid of the breast cancer once and for all, and considering that the cosmetic result of immediate reconstruction after mastectomy is so appealing. How does one discuss the patient's disease and the risks and benefits of the treatment options and obtain informed consent to proceed with definitive surgery, given that the tissue obtained by stereotactic needle core biopsy may not be a representative sample of the tumor being treated?

The authors also make a point of demonstrating the cost-effectiveness of stereotactic needle core biopsy. This may be true in some cases in the short run. However, what about the patient who has a needle core biopsy to sample a cluster of microcalcifications, who returns 2 years later with more calcifications in the same area, or with some distortion or change in the breast stroma and with no one able to determine whether there has been an increase in the number of calcifications? Many patients are better served with a once-and-for-all needle localization and excisional biopsy.

I think that our challenge as surgeons is to resist the hoopla of equipment manufacturers trying to create a market to sell expensive new technology and critically evaluate that new technology in terms of patient management and whether it adds anything meaningful to patient comfort. With stereotactic needle core biopsy currently available on every street corner, I frequently am left out of the loop, with the gatekeeper and the radiologist collaborating to work up patients with breast disease, who then arrive at my office with a devastating diagnosis and incomplete information on which to base a decision about definitive therapy. Needle localization and biopsy really is not so terrible an ordeal, and many patients who have endured both prefer open biopsy to stereotactic biopsy.

I currently use stereotactic needle core biopsy primarily to confirm the diagnosis of nonpalpable breast cancers in patients who do not want breast conservation surgery (patient's personal preference). Because most patients with breast cancer want and may be candidates for breast conservation, knowledge of the morphologic characteristics of the tumor is essential in helping the patient to understand the risks and benefits of the treatment options from which they are asked to choose. My experience has been that these morphologic characteristics are obtained more reliably by needle localization and excisional biopsy.

Reference

1. Yim JH, Barton P, Weber B, et al. Mammographically detected breast cancer: benefits of stereotactic core *versus* wire localization biopsy. Ann Surg 223:688–700.

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July 31, 1996

Dear Editor:

We thank Dr. Siegel for his careful reading of our paper, and appreciate his pointing out the ways in which his practice differs from ours. Dr. Siegel has three main criticisms of our recommendations, and then describes the limited use he makes of the stereotactic core needle biopsy (SCNBx) technique.

First, in Dr. Siegel's opinion, stereotactic core needle biopsy does not provide an adequate, representative sample on which to base recommendations for definitive therapy. This is not