

Correspondence

Sir,

re: A series of 11 patients with angiosarcoma of the breast (The Breast 1993; 2: 171–174)

I read the comments on this paper by Dr Page and Dr Donnell with interest. Our paper on angiosarcoma of the breast did not demonstrate that grade did not relate to outcome, because '... with such a small series it is difficult to be certain that grade does not correlate with outcome'. Although it is true that one patient classified as having a grade I angiosarcoma died of this disease, a similar patient died in the series reported by Dr Donnell in 1981. We know that one case does not demonstrate anything and that 'one swallow does not make a spring'. From our limited series of cases we simply stated that a clear correlation between grade and outcome was not apparent. One other point and that is that Drs Page and Donnell stated in their comments that one death was from a very large tumour but in fact the tumour itself was only 2 cm in diameter which is not large.

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Sir,

re: For debate: Post-treatment mammography following breast-conserving treatment (The Breast 1993; 2: 253–254)

Barr and colleagues¹ deny the usefulness of post-treatment mammography as it gave no independent contribution to the detection of nine consecutive breast recurrences observed in their series. They also suggest that suspicious lesions should be assessed with TRUCUT or open biopsy as they found cytology of the irradiated breast to be unreliable.

In a recent review² of a consecutive series (1983–1992) of 1400 women treated with breast conserving therapy and followed up with physical examination (every 4–6 months for the first 3 years, then yearly) and yearly mammography for a median period of 4 years (range 1–9), we observed 102 histologically confirmed breast cancer recurrences. Of these, mammography

failed to be detected in 41% of cases at the time of diagnosis, but was the only test to suspect recurrence in 17 cases.

84 of 102 recurrences were studied by aspiration cytology which was suspicious in 65 of 68 (96%) adequate cases, a figure consistent with the accuracy currently reported for breast cytology.³ Cytology was the only test to suspect recurrence in 17 cases. No false positives were recorded.

Although we agree that mammography of the irradiated breast is less sensitive than in the normal breast, it still allows early detection of subclinical recurrences and should be part of routine follow-up. Such a diagnostic anticipation may have a limited relevance to prognosis for primary invasive carcinomas, but may be important in the follow-up of conservatively treated DCIS, which often recur as invasive carcinomas.⁴

In the series reported by Barr and colleagues screening by mammography detected no subclinical contralateral cancers. Although the sample size was small, this figure suggests a lower sensitivity of mammography to that currently reported in the literature. Adopting the same rationale as for recurrence contralateral cancer, the logic is that, mammography follow-up of the contralateral breast should also be abandoned.

From our data fine needle aspiration cytology has the same accuracy in normal or irradiated breasts and is extremely useful for the assessment of breast abnormalities after conservative treatment.

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References

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