Malignant adenomyoepithelioma of the breast

Sir,
I read with interest the article by Attili et al. [1] in the recent issue of the IJS. We also have the experience of two such cases at our department who were diagnosed only after histopathological examination.

However, I fail to understand what made the authors do a mammogram, a computed tomography (CT) of the thorax and abdomen and a bone scan. The examination findings (though not clearly stated) revealed a breast lump about 4 cm in size. Even by staging the patient had a stage IIB disease with normal hematologic and biochemical parameters.

As per the NCCN (National Comprehensive Cancer Network) Clinical Practice Guidelines on Breast Cancer 2007 [2] for patients in Stage I (T1N0M0), IIA (T0N1M0, T1N1M0, T2N0M0) and IIB (T2N1M0, T3N0M0, T3N1M0), the recommended investigations are as follows:
1. History and physical examination
2. Complete blood count, platelets
3. Liver function tests (LFTs)
4. Chest imaging
5. Diagnostic bilateral mammogram or ultrasound as necessary
6. Pathology review
7. Determination of estrogen receptor (ER) / progesterone receptor (PR) / human epithelial growth factor receptor 2 (Her-2) status
8. Breast magnetic resonance imaging (MRI) (optional)
9. Bone scan (optional) (Indicated if localized symptoms or elevated alkaline phosphatase or if T3N1M0) (category IIB)
10. Abdominal CT or ultrasound (US) or MRI (optional for stage IIA or IIB, indicated if elevated alkaline phosphatase, abnormal LFTs, abdominal symptoms, abnormal physical examination of the abdomen or if T3N1M0) (category IIB)

The Indian Comprehensive Cancer Network Guidelines (ICCN) on Breast Cancer (2005) [3] advise the following for diagnosis of operable breast cancer (T < 5 cm ± mobile lymph nodes):

Diagnosis
- Physical examination
- Optional (mammography / ultrasonography)-include both axillae.

Tissue Diagnosis
- Fine needle aspiration cytology/core biopsy
- Excision biopsy
- Frozen section
- Incision biopsy (only when neoadjuvant therapy is planned)
- Staging: metastatic workup, not mandatory

Mallika Tewari
Department of Surgical Oncology, Institute of Medical Sciences, Banaras Hindu University, Varanasi - 221 005, India.
E-mail: mallika_vns@satyam.net.in

REFERENCES

How to write a scientific paper

Sir,
An excellent article from Shukla [1] on a very important and relatively less discussed topic. Writing a scientific paper has innumerable benefits to both the author and the reader. Some of these are:
1. It helps in developing analytical thinking. Analytical and lateral thinking teases out differences between what seems to be right and what is right.
2. Published papers raise your profile in the profession
and help career growth.
3. A paper does not have to be a rare case or a rare hypothesis. It can very well be a common topic or subject with a message to take home.
4. Published literature gives clinicians a standard with which they can compare themselves.\[2\]
5. One is more protected medicolegally if one has a practice that is consistent with published scientific material.

Sanjay Dalmia
Department of Surgery, Calcutta Medical Research Institute, Kolkatta, India. E-mail: dalmiasanjay@hotmail.com

**REFERENCES**

**Comment on: Role of water-soluble contrast study in adhesive small bowel obstruction: A randomized controlled study**

Sir,
I read this above-mentioned article with interest.\[1\] I have some serious questions regarding this study and I want to know the opinions of the editor and the experts in the field.

1. Authors say that waiting for 24-48 hours to see the results of Gastograffin reaching the colon is safe and reliable and helps in the management of acute intestinal obstruction due to postoperative adhesions.

All surgical textbooks advise us never to allow the sun to rise or set over an obstructed bowel. That means, if you get a case of intestinal obstruction in the night, laparotomy must be performed before the morning and if the you get the case in the morning, the laparotomy should be finished before the night. The danger is in delay and not in the surgery. Of course, there may be a few cases in which, depending upon clinical signs and symptoms, a few hours of observation may be safe. But this cannot be advised in general for all cases.

2. The authors have not mentioned operative findings in the results’ section, which is a very critical omission. (How many cases required bowel resection in the study and control groups?)

3. The authors have mentioned that five patients required surgery contradicting their own statement in the “materials and methods” section: “…..all patients in whom radiological contrast didn’t reach the caecum within 24 hours was operated”. What made the authors operate on these five patients violating their protocol of the study?

4. In the materials and methods section, they describe their method of selection to be allotting the patients alternatively to study and control groups. If this is done properly, each group should get 16 out of 32 cases and not 17 and 15 as mentioned in the study.

5. ROC curve. The graph plotted with sensitivity vs 1-specificity.

What does it depict / explain? Explaining the curve, authors say, “…it can be seen from the graph that maximum area of the curve (~85%) lies between 12 and 18 hours. Actually, the graph neither shows 85.5 nor any time interval of 12–18 hours. What are the authors trying to say?

6. Sensitivity 100% and specificity 60%: (Or should it be sensitivity 60% and specificity 60%). Sensitivity 100% means not even a single pathological case should be missed, i.e, there should not be any false negative case. Here two cases required surgery where the test suggested “no surgery”. What is the formula that the authors have used to arrive at the figure of 60% specificity? (Or is it 14/17 x 100 = 82.35?).

7. In the results, the authors have mentioned that five cases were operated within 24 hours. Again they mention “…..14 of 17 cases oral feeding started as contrast reached caecum within 24 hours”. How