BRITISH MEDICAL JOURNAL

SATURDAY 22 APRIL 1978

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

NO 6119 BRITISH MEDICAL JOURNAL 1978 VOLUME 1 1007-1088
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

ASTM CODEN: BMJOAE 1 (6119) 1007-1088 (1978)
WEEKLY. SECOND CLASS POSTAGE PAID AT NEW YORK NY

CORRESPONDENCE

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

If my wife had cancer of the breast

SIR,—What a pity that Professor Harold Ellis (8 April, p 896) should inject an emotional and irrational note (I can talk like this because we were once registrars together) into an otherwise warm, sane, and balanced essay.

Mastectomy and local excision seem to be followed by similar survival rates, but local recurrences are fewer after mastectomy. Postoperative radiotherapy and no postoperative radiotherapy are also followed by similar survival rates, but again the local recurrence rate is less after radiotherapy. Quite good evidence is available on both counts and the advantages and disadvantages of each choice seem to be rather evenly balanced. Professor Ellis seems at first to accept this. Then suddenly all his calm judgment and lack of prejudice fly out of the window and we hear that (although "a mutilating operation will be required") he will be "*very anxious indeed*" (my italics) "for his wife not to be irradiated at this stage."

I am reminded of another surgeon writing about breast cancer 20 years ago who spoke on one page (if I exaggerate I do so only very slightly, I promise you) of the remarkable and heartening response of 50% of advanced cases to adrenalectomy (his operation) and on the next page of how he could not recommend hypophysectomy (a treatment he was unable to perform himself) because it completely failed in half the cases in which it was tried.

THURSTAN B BREWIN

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SIR,—Professor Harold Ellis (8 April, p 896) presents a soundly conventional approach to the treatment of a woman with breast cancer, but why was a male surgeon selected to write on this subject under the general heading of "If I had . . ."? I hope a woman surgeon will be invited to give her views on breast cancer in the near future—or has she already been retained for "If my husband had carcinoma of the prostate"?

Having said that, as a histologist endlessly intrigued by the differing inflammatory and fibrotic reactions round cancer cells—and as a morbid anatomist too often seeing the best-laid plans of mice and men go sadly astray—may I air a less conventional male view on breast cancer? I believe, if I were a woman and if I had clinically localised cancer of the breast, I would not have a mastectomy. I would have a lumpectomy, probably not thereby altering my life expectancy but certainly leaving me a "complete" person. Also my whole family and circle of friends would not necessarily know that I had cancer, as they would following a mastectomy. These advantages I would gladly accept against an undetermined increase in the odds of a local recurrence. I would look to my general health in the belief that this affects the natural defences against cancer and I would not damage those defences by taking cytotoxic immunosuppressants. Finally I would inquire from my biochemist colleagues what non-toxic substances—such as amino-acids—are needed for the formation of the complex proteins that are cancer antibodies. I would then take a cocktail of "essence of antibodies" once a day in the firm belief that it would help my body fight my disease.

Off beat, and some would say a gamble; but the whole of life is a gamble, so I would want to back the horse which offered the only reasonable chance of a complete cure. With support from their medical and surgical advisers perhaps some women might feel the same?

A R KITTERMASTER

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Hyperprolactinaemia and pituitary tumours

SIR,—We read with interest the article by Dr T Bergh and others (8 April, p 875) describing the outcome of drug-induced pregnancies in women with prolactin-secreting pituitary tumours.

Since none of the women had pituitary surgery or radiotherapy, the publication of complications of tumour expansion during pregnancy is of major importance now that bromocriptine is available to induce fertility. Seventeen pregnancies went to term in 14 women; there were symptoms of visual defects in two patients and severe headache developed in a third patient; two patients had radiological evidence of expansion of the sella turcica; a total of four patients were judged to have had features of tumour expansion out of the 25 pregnancies observed.

In an attempt to prevent tumour expansion during pregnancy and yet not to impair fertility we have treated a comparable series of 21 young women with low-dose (20 000 rads) pituitary implants of yttrium-90. Follow-up is from one to 76 months (mean 27). There have been no complications arising from the operation and no significant impairment of other pituitary functions if normal before operation. There was, however, a significant fall in median serum prolactin concentration by 60% as at the latest assessment ($P < 0.01$), which compares favourably with published results of transfrontal and trans-sphenoidal surgery.[1] Thirteen of our patients desiring fertility have been followed up with these results: nine (70%) became pregnant, and, since four patients became pregnant twice, a