BRITISH MEDICAL JOURNAL

SATURDAY 25 AUGUST 1979

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NO 6188 BRITISH MEDICAL JOURNAL 1979 VOLUME 2 457-510
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

ASTM CODEN: BMJOAE 2 (6188) 457-510 (1979)
WEEKLY. SECOND CLASS POSTAGE PAID AT NEW YORK NY

CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Needle aspiration of the breast

SIR,—As I have for some 15 years been an ardent protagonist of fine-needle aspiration biopsy in all its aspects, it was naturally a pleasure and encouragement to read the paper from Dr Helen L D Duguid and surgical colleagues regarding its application to the breast (21 July, p 185). Several points raised in this article are worthy of comment.

One of my earlier papers is quoted "as emanating from a newly established breast clinic and demonstrating an unacceptably high incidence of false-negative reports and unsatisfactory preparations." This is untrue. My work developed not in a breast clinic with special supporting facilities but in an overloaded general surgical outpatient department with major teaching obligations to students. (The latter, incidentally, are most useful to wave dry the slides.) Both this preliminary aspect[1] and the later more definitive publication[2] showed that the overall accuracy of needle aspiration for breast lumps and lumpiness lay at 97% and the unsatisfactory smear rate was 0·6%. These figures compare favourably with those from several large published series from centres of cytological excellence and vast experience.[3–5]

Whereas results vary from year to year the ongoing accuracy rate remains around 95%, which is acceptable for clinical work provided that certain basic rules are observed.[2] The essence of fine-needle aspiration biopsy—which is both rejected and decried by many British surgeons—is that it should remain a simple technique which does not hold up the proceedings. I wonder if Dr Duguid's method of preparation of material is overelaborate and may deter others from adopting aspiration biopsy.

I remain unconvinced that wet fixation and Papanicolaou staining confer any advantage over the simpler, cheaper, and more versatile air drying, Romanowsky style. I adhere to my preference for the "braced-thumb" trick[2] to ensure constant suction and always reduce suction before the needle is withdrawn. The syringe pistol (necessarily modified) is not a cheap item and although provided in a set clinic environment is not usually available when aspiration biopsy is performed elsewhere. One can also sense the texture of a breast lump rather better with the "braced-thumb" method. I regard local anaesthesia as superfluous and a 20 ml syringe far more reliable than a 10 ml size to obtain an adequate yield.

For NHS patients our cytology laboratory, which is situated in another hospital, reads the Giemsa or May-Grunwald Giemsa smears within 24 hours and we possess the report by 36 hours. This is added to the clinic letter for the general practitioner. If an immediate report is imperative this can be obtained within the hour. To organise the facility for rapid reporting that is achieved in Dundee would place far too great a strain on our laboratory staff. Yet I feel that our practice of aspiration biopsy for breast and other lesions provides a good service to the patient, general practitioner, and medical staff alike; it also allows investigations to be sensibly organised.

It was perplexing to read that the surgical team accepted the cytological report of malignancy for informing the patient and arranging expensive scans, but demanded the rather unsatisfactory performance of excision biopsy with frozen section before proceeding to surgery. Over the past 13 years it has been the exception in my practice to require frozen section before embarking on mastectomy.