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CORRESPONDENCE

We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Tuberculosis of the breast

SIR,—The report by Dr M C P Apps and others (23 June, p 1874) usefully reminds us that tuberculous mastitis is a diagnosis often made overconfidently by those aware of the disease but unfamiliar with conditions that may mimic it. In over 30 years I have collected a series of 44 cases of caseating granulomatous mastitis, and in only six was tuberculous infection proved (table).

Perhaps a need to condense their paper prevented the authors from making the point that the diagnosis was proved in only two of their five cases. It is well known, and should be better known, that "histological findings typical of tuberculosis" are diagnostic only when *Mycobacterium tuberculosis* is isolated from the lesion or perhaps from matter obtained from the lesion. Even the microscopical demonstration of acid fast bacilli is not necessarily evidence of tuberculosis unless their identity is confirmed by their cultivation.

A standard work on mammary pathology notes: "It is worth remembering . . . the necessity of identifying tubercle bacilli in the lesions before interpreting granulomatous disease as tuberculous"[1]; and another: "Not only biopsy findings but bacteriological verification is requisite for the diagnosis."[2] A clinician wrote in the context of tuberculosis of the breast: "Modern pathologists have come to realise that a great variety of granulomatous processes . . . produce microscopic pictures indistinguishable from tuberculosis."[3] To ignore such experience is to risk danger to patients, and this should be in one's mind when thinking of entering a diagnosis of tuberculous mastitis in a patient's records and when preparing publications.

Even when tuberculosis is present in a breast there is always a possibility that it is associated with another and perhaps even more serious disease, particularly cancer. Coexistence of proved tuberculosis and cancer in a breast is very rare, but it is not so rare that the diagnosis of tuberculous mastitis may be regarded as excluding the presence of the other. No doubt the granulomatous condition in many of the

*Final diagnosis in 44 cases of caseating granulomatous mastitis initially diagnosed histologically as tuberculous (1947-83)**

Final diagnosis	No of cases	Geographical source of disease
Proved tuberculosis:		
M tuberculosis isolated	6	Hong Kong; India (2); Ireland; Pakistan; Scotland
Presumptive tuberculosis:		
M tuberculosis not isolated but acid fast bacilli present in histological sections or films of matter from lesion or both	5	England; East Africa (Asian woman); India (Scotswoman); Indonesia; Norway
Other proved infections:		
Tularaemia (following penetrating wound)	1	Germany
Syphilis (gummatous mastitis, with softening)	1	England
Lymphogranuloma inguinale (confined to breast)	1	India
Blastomycosis (*Blastomyces dermatitidis*)	1	Ethiopia
Chromomycosis (*Phialophora gougerotii*)	1	India
Cryptococcosis (cryptococci not seen until third biopsy)	1	Scotland
Histoplasmosis (*Histoplasma capsulatum*)	1	Malaysia
Phycomycosis (*Conidiobolus coronatus*)	1	Malaysia
Sporotrichosis	1	Ireland
Metazoal infestation:		
Cysticercosis (*Taenia solium*)	1	India
Hydatid cyst (*Echinococcus granulosus*)	1	Pakistan
Pentastomiasis (*Armillifer armillatus*)	1	Malaysia
Iatrogenic:		
Mastoplasty (injection of liquid or soft paraffin)	2	England; Thailand
Packing of cavity of true abscess with gauze impregnated with medicated soft paraffin	3	England (2); Sri Lanka
Endogenous granulomas:		
Complicating mammary duct ectasia; after aspiration/incision/rupture of milk cyst; after trauma	7	
Uncertain cause:		
Histological findings consistent with tuberculosis but no acid fast bacilli found and cultures (if any) yielded no pathogens; no evidence of any other condition; diagnosis therefore considered likely to be tuberculosis but with no bacteriological support	9	East Africa (2 Asian women); England; France; India (2); Ireland; Pakistan; Scotland

*Most of the patients were seen in Britain; about a third were seen in the course of visits to surgical pathology services overseas.