

his health would have suffered and he might well have lost his job.

It must be understood that the best form of life insurance that this man could have taken was to obtain medical advice and help rather than spend more money on insurance premiums. I would therefore like to suggest that, in order to protect our patients, doctors should not be expected to disclose any information about alcohol consumption. This information must be obtained directly from the proposers themselves by the insurance companies.

I would like to see the BMA produce a set of guidelines giving doctors an idea of what they should disclose and what they should not. I have already mentioned alcohol and tobacco consumption, but the same problems apply to many other conditions ranging from drug abuse to chest pains. In many of these conditions information could be withheld from a doctor for fear of the patient being unable to obtain life insurance. If such guidelines could be produced, then it would go a long way towards reducing any conflict between the patients, the insurance companies, and the doctors.

T M PICKARD

Great Waltham,  
Chelmsford, Essex

### Breast lumps in adolescent girls

SIR,—I have read with interest the opening statement of your leading article on this subject (4 February, p 260), which comments on the "steady trickle of frightened young girls" seeking advice about breast problems. I have found a similar trend in our well woman breast screening clinic.

The women attending the clinic submit themselves for the first visit, the only limits at this stage having been the availability of appointments and age of the women—that is, at least 35 years. The waiting list is opened at specified intervals and the first 150 applicants are accepted. Forty to fifty applications per week are refused between these specified dates. From this self-selected group high-risk women are abstracted for annual review on the grounds of personal and family history and the results of the initial screening by clinical examination, thermography, and mammography.<sup>1,2</sup> The aim of the clinic is to screen a cohort of high-risk women at annual intervals, so few appointments have been available for new entrants in recent years.

Significant trends have appeared in the self-selection over the years. In 1968 31% were in the high-risk group; by 1976 this figure was 62%. It is assumed that this increase in the self-selection of high-risk groups is due to public education.

Until mid-1977 there was a satisfactory spread of ages in the self-selected group, as shown in the accompanying table, which also indicates the percentage of total cancers according to age group. In the second half of 1977, however, there has been a marked change in the age groups of women seen for the first time at the breast screening clinic (see table). Questioning these women indicates that various articles in the media have caused undue concern in the younger women, who are swamping the clinic at the expense of the older women. No cancers were found in the under-40 age group.

In spite of the fact that 7.2% of all the registered breast cancers in this region occur

Age distribution of women being screened for first time and of confirmed cases of cancer among them

Age group (years)	1968–July 1977		August–December 1977	
	Percentage of total screened	Percentage of total confirmed cancers (216)	Percentage of total screened (436)	Percentage of total confirmed cancers (11)
35–39	5.9	8.3	34	—
40–50	44.9	53.9	50	51
51+	49.2	37.8	16	49

in women of 39 years or younger I have decided that, while resources are limited, the lower age limit for screening must be raised to 40 years, so giving more opportunity for screening to older women. It would appear that the effects of public education in medical matters are not so completely beneficial as some people believe.

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AGNES M STARK

Breast Diagnostic Clinic,  
Queen Elizabeth Hospital,  
Gateshead, Tyne and Wear

<sup>1</sup> Stark, A M, in *Breast Cancer, Trends in Research and Treatment*, ed J C Heuson, p 279. New York, Raven Press, 1977.

<sup>2</sup> Stark, A M, *Acta Thermographica*, 1976, 1, 33.

SIR,—In recent years there has been a great increase in interest in cancer of the breast and its early diagnosis and in other conditions of the breast which could be confused with cancer or which could predispose to it or precede it.

I thought it would be interesting to consider which breast complaints or breast abnormalities arose in a young population. I looked at the records of every person attending the University Health Service between 1 January 1976 and 1 January 1978 who either came with a specific breast complaint or who, on routine examination for another purpose, was found to have a breast abnormality sufficient to warrant inclusion in the diagnosis or diagnoses following the consultation. The numbers are accurate in that a diagnostic card index was kept and when the day's consultations were reviewed for record purposes I marked each case to be included on the diagnostic card. The investigation was not prospective (but for the same reason perhaps more informative) in that my colleagues did not know what information I was collecting and did not take this into account when making their notes. There are approximately 6500 patients, of whom just over a third are women, registered with the University Health Service for NHS purposes, and these are almost all students—staff are not eligible except for a very few resident in an official capacity in a hall of residence.

The number of patients included on the diagnostic card with the criteria laid down was 128. Of these 107 (group 1) were born in 1952 or later (and were 25 years of age or younger at the mid-point of the two years) and 13 (group 2) between 1952 and 1947 (and were between 25 and 30 years at the mid-point of the two years). Eight patients were older and were excluded from those in the figures now given.

Of the 120 patients (group 1, 107; group 2, 13), 13 (group 1, 12; group 2, 1) were males. Forty-five (group 1, 39; group 2, 6) were referred for a second opinion, although one

failed to attend, and 74 (group 1, 67; group 2, 7) were not. Of those referred only four (group 1, 3; group 2, 1) were subjected to biopsy and none of the specimens showed any malignancy. A fifth patient included among the 45 had had a fibroadenoma removed in 1975. Forty-two (group 1, 36; group 2, 6) of these patients presented with a swelling (including inflammatory) or "lump" of the breast. In four cases (group 1, 3; group 2, 1) a lump could not be confirmed when the patient was seen and in many the "lump" was part of a more generalised nodularity. In a case not included in the 42 a lump had been removed previously elsewhere, although there was no lump at the time we saw her. Twenty-five (group 1, 20; group 2, 5) were complaining of breast pain or tenderness. Other presenting symptoms included galactorrhoea, inflammatory lesions, skin conditions, pendulous breasts, unequal breasts, injuries to the breast, symptomless fear of breast cancer, unilateral breast enlargement and secretion premenstrually, embarrassment about small breasts, nipple retraction, and gynaecomastia (including adolescent male mastitis). A large number of the girls were, of course, on the pill, and this probably made them more conscious of breast symptoms and the possible implications of these, as well as in some cases contributing to them.

Thus in two years over 100 girls below the age of 25 were seen with breast complaints and abnormalities. These covered a wide spectrum of conditions, but none of them was malignant.

D McCRACKEN

University Health Service,  
Leeds

### Carcinoma in a gastroenterostomy stoma

SIR,—In their report of a case of adenocarcinoma occurring in a gastroenterostomy stoma (21 January, p 151) Drs Rose Buchanan and M J Sworn claim that "even when a gastroenterostomy has been performed only a minority [of gastric carcinomas] have been restricted to the stoma itself." Reported series of gastric carcinoma occurring many years after surgery for benign conditions all document the area of the anastomosis as being the commonest site for carcinoma to occur. This seems to be the case whether the previous surgery has been partial gastrectomy<sup>1–3</sup> or just gastroenterostomy alone.<sup>4–6</sup>

S M JONES

University Department of Surgery,  
Bristol Royal Infirmary,  
Bristol

<sup>1</sup> Schrupf, E, *et al*, *Lancet*, 1977, 2, 467.

<sup>2</sup> Pack, F T, and Banner, R L, *Surgery*, 1958, 44, 1024.

<sup>3</sup> Bushkin, F L, *Major Problems in Clinical Surgery*, 1976, 20, 106.

<sup>4</sup> Morgenstern, L, Yamakawa, T, and Seltzer, D, *American Journal of Surgery*, 1973, 125, 29.

<sup>5</sup> Hammar, E, *Acta Pathologica et Microbiologica Scandinavica*, section A, 1976, 84, 495.

<sup>6</sup> Kobayashi, S, Prolla, J C, and Kirsner, B J, *American Journal of Digestive Diseases*, 1970, 15, 905.

### Yawning in pharyngeal obstruction

SIR,—After observing two infants in the early stages of choking, I wish to draw attention to yawning as a symptom of pharyngeal impaction.

In the first infant, aged 11 months, an acute episode of obstruction occurred immediately