difficulties with the passage of time. Indeed, we are at present examining data from the five-year follow-up of our cohort, and our evidence so far suggests that difficulties may gradually increase in intensity. A number of recent studies have shown similar levels of emotional morbidity (that is, 20-30%) in newly diagnosed cancer patients.[3-6]

It is none the less clear that most patients recover remarkably well from traumatic experiences such as mastectomy and diagnosis of cancer. A "blanket" service for all such patients is not only unnecessary but may be unwanted. It is also clear from the studies we have cited and from our own work that clinical symptoms of depression and inability to return to a previous life style are not a "natural" response even to a life event as threatening as a diagnosis of cancer, whatever the prognosis. What is needed is to identify predictors of poor psychosocial outcome following mastectomy. In our own study, patients who failed to recover psychologically or who were unable to resume their social roles fell into clear at-risk categories, detectable at the time of operation:

(1) Patients likely to experience depressive symptoms needing medical attention were those who had clear clinical signs of depression at the time of operation, regardless of their previous psychiatric history.

(2) Patients most likely to experience sexual difficulties were those who were biologically or chronologically (that is, aged about 50) perimenopausal.

(3) Patients likely to remain stressed by anxieties about their diagnosis were those who had a strong component of emotional lability as measured by the Eysenck Personality Inventory Neuroticism Scale in their personalities: that is, the visibly anxious patient with somatic evidence of anxiety.

Thirty-three per cent of our cancer patients were also dissatisfied with the information they received.

No service can adequately assuage private grief at the loss of a valued body part. What is important is that surgeons, physicians, radiotherapists, and general practitioners treating breast cancer patients recognise and themselves treat or refer depression, anxiety, or sexual problems so that patients may resume their previous level of functioning as quickly as possible. Skill in recognition, at least, in these areas should be part of the armoury of any medical practitioner. Creation of a milieu where patients feel free to voice their anxieties will assist this recognition and therefore the provision of appropriate help.

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If I had . . .

SIR,—In a recent article in this journal (8 April, p 896), Professor Harold Ellis indicated that if his wife developed clinically early breast cancer he would wish a preoperative skeletal survey to be carried out, presumably to exclude asymptomatic bony metastases. There is now considerable evidence that the *x*-ray skeletal survey is an insensitive means of detecting bony metastases in breast cancer and that an isotope bone scan is superior.[1-3] There is some debate over the exact incidence of scan-detectable bony metastases in clinically early breast cancer (British Breast Group, unpublished data), but such abnormalities have been shown to have grave prognostic significance.[4 5]

Like Professor Ellis we would wish to exclude occult skeletal metastases if our wives presented with clinically early breast cancer and suggest that the best means at present available for assessing this, both at the time of presentation and during follow-up, is a bone scan using a ^{99m}Tc-labelled phosphate agent. If this is normal no further studies are necessary. If the scan shows abnormalities, then selected *x*-rays of the abnormal areas should be performed to exclude benign skeletal disease.

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SIR,—Your new series got off to a promising start with a thoughtful consideration by a distinguished surgeon of his actions and reactions if his wife had breast cancer. I hope that later we may have a woman doctor's essay on the same theme. There are unmistakable sex differences in attitudes to this disease, which may sometimes be ill understood by men. About four years ago, I asked an examination question in a first-year medical course on behavioural science which illustrates this point. I stated the fact that a high proportion of women who discover lumps in the breast delay seeking treatment, sometimes for many months, and asked the students for a brief statement of the possible reasons. The question was answered by virtually all of the 30-odd women in the class and by about an equal number of the men. The men gave the conventional, expected answer (fear of cancer, the hope that the lump would go away, reluctance to leave the family to enter hospital, economic reasons, and guilty feelings that the lump was a punishment for sexual sin—all of this had been mentioned in the class). The women students gave the same reasons with an additional one on which many waxed eloquent. Recall that these women were in their late teens or early 20s. The extra reason they gave was that the current methods of treatment are an assault on a woman's sexual identity. Men can best understand this by considering how they would react if they suspected they had cancer of the penis. Perhaps the treatment of breast cancer, including its psychological implications, will improve when more women graduates enter specialties such as surgery and clinical oncology.

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SIR,—The criticisms in your issue of 22 April (p 1050) of Professor Harold Ellis and his views on cancer of the breast seem a little unfair. Professor Ellis was presenting a sound balanced view which is acceptable for most thinking members of the profession. It is, perhaps, unfortunate that he omitted to consider reconstruction of the breast, but this was, perhaps, part of his brief. It surely seems an obsolete approach now to do a lumpectomy if the sole reason is a cosmetic one. It is now widely accepted that it is possible to remove the breast and reconstruct it using an implant, and this would seem a more logical approach. Many surgeons now perform this procedure and your correspondent might be interested to know that there was to be a symposium on the subject at York on 5 May.

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SIR,—Surely Dr T B Brewin (22 April, p 1050) rather misses the point about Professor Harold Ellis's essay (8 April, p 896) "If my wife had breast cancer." If a doctor is in the position written about by Professor Ellis, it is only normal that he would be emotional and even irrational about things—he's a human being like everyone else. It is easy to sit back and be rational when you're not personally involved, but as soon as it is yourself or your wife, child, father, or mother involved rationality is not exactly your first concern in the situation. You don't run a series entitled "If I had . . ." just to get people's clinical opinions.

CHRISTOPHER WAYTE

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SIR,—Dr J M S Pearce (15 April, p 969) has put the cart before the horse. If I had a right ocular transient ischaemic attack like his I would put my stethoscope bell on the middle of my right carotid and not beat about the bush in the manner he described. A good GP friend of mine referred himself to me some years ago in just this manner and I operated on his stenosed carotid a couple of days later.

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SIR,—How strange that Professor H A F Dudley (22 April, p 1035) should omit a good radiotherapist from his list of experts to manage his rectal cancer. As long ago as 1963[1] surgeons had recognised the potential in radiotherapy for eradicating local recurrence from this disease. Postoperative radiotherapy was tried and failed (as many had predicted from their experience in irradiating the female pelvis) because the complication rate is too high.

The logical alternative, preoperative radiotherapy, followed by radical excision, seemed a much more attractive proposition from practical as well as radiobiological considerations. The sceptical rectal surgeon could have taken heart from his "commando" colleagues specialising in the head and neck who regularly perform radical neck dissection after high doses merely by getting their timing right. This approach has now been vindicated and a Medical Research Council trial set up. Local recurrence is reduced to zero and no increase in operative morbidity or mortality occurs—indeed the combined operation is said to be easier.[2]

There remains the objection that his pelvic nodes might have been needlessly irradiated