

rare, but a number of cases have been reported in the literature.<sup>1,2</sup> We report here a further case.

A 45-year-old perimenopausal woman was referred to our institution after excisional biopsy of a long-standing mass in the left breast that had revealed infiltrating duct carcinoma. Three months later there was a recurrence at the same site.

There was no history of tuberculosis or other illness. General physical examination revealed nothing abnormal. Examination of the breasts revealed a mass in the left breast, measuring 8 × 6 cm around a horizontal 5-cm scar in the central quadrant. The nipple-areola complex was absent. The mass was nontender, mobile, hard and fixed to the overlying skin but not to the chest wall. Ipsilateral fixed lymphadenopathy was present.

Mammography suggested that the mass was malignant. Fine-needle aspiration (FNA) of the mass revealed numerous epitheloid cell granulomas and Langhans giant cells in a background of inflammatory cells, capillary fragments and necrosis. In addition, there were few atypical duct cells. Staining for acid-fast bacilli gave strongly positive results. FNA of the axillary mass revealed fat mixed with ductal epithelial cells, showing minimal pleomorphism. An axillary lymph-node biopsy showed metastatic adenocarcinoma. A review of the histologic findings obtained from the previous surgery confirmed infiltrating duct carcinoma, grade I. The Mantoux test gave positive results and the erythrocyte sedimentation rate was elevated. Work-up for metastatic disease gave negative results.

Combination chemotherapy was begun (5-fluorouracil, doxorubicin and cyclophosphamide) along with combination-drug treatment for tuberculosis (rifampin, isoniazid, pyrazinamide and ethambutol). The masses had disappeared by the third cycle of chemotherapy. Total mastec-

tomy with axillary clearance was carried out after 4 cycles of chemotherapy, as is our protocol for locally advanced breast cancer. Histologic examination of the excised tissue showed areas of necrosis surrounded by palisading histiocytes, epithelial cells, fibroblasts and Langhans giant cells surrounded by lymphocytes. Areas of adenosis and epithelial hyperplasia and hemosiderin deposits were also seen. All lymph nodes showed reactive hyperplasia. There was no evidence of malignancy in the excised specimen, and staining for acid-fast bacilli gave negative results. Postoperatively the patient continued with the antituberculosis treatment and combination chemotherapy.

### Comment

Sir Astley Cooper first described mammary tuberculosis in 1829,<sup>3</sup> and fewer than 700 cases have been described to date.<sup>4</sup> In 1925, Nagaskima<sup>5</sup> showed that the breast was the only organ to be spared in 34 patients who had disseminated disease.

Mammary tuberculosis usually affects young women (20 to 40 years of age), especially lactating multiparous women. It is rare in men and in elderly women and prepubertal girls. Bilaterality is rare.<sup>3,4</sup> The primary form is caused by blood-borne organisms, and no other focus should be present. Secondary invasion of the breast can occur via blood, lymphatics or by direct extension. Mammographic findings may suggest malignant disease in many cases.<sup>3,4</sup>

Our patient was treated with a combination of antitubercular drugs and combination chemotherapy, which brought about a complete pathological response. Neoadjuvant chemotherapy is standard care for locally advanced breast cancer, and our experience shows that it can also be used successfully with anti-

tuberculosis therapy to treat patients such as ours.

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### References

1. Grausman RI, Goldman ML. Tuberculosis of the breast: report of nine cases including two cases of co-existing carcinoma and tuberculosis. *Am J Surg* 1945;67:48-56.
2. Kaplan MH, Armstrong D, Rosen P. Tuberculosis complicating neoplastic disease. A review of 201 cases. *Cancer* 1974;33:850-8.
3. Wilson TS, MacGregor JW. The diagnosis and treatment of tuberculosis of the breast. *CMAJ* 1963;89:1118-24.
4. Hale JA, Peters GN, Check JH. Tuberculosis of the breast: rare but still extant. Review of the literature and report of an additional case. *Am J Surg* 1985;150:620-4.
5. Nagaskima Y. Role of tuberculosis in female breast in presence of tuberculosis of internal organs and especially in miliary tuberculosis. *Virchows Arch [Cell Pathol]* 1925;254:184.

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### Education versus service

After reading Waddell's Editors' View in the October 2000 issue of the *Canadian Journal of Surgery* (page 326), we are still searching for the "controversial" theme, which was extracted from it and translated into a front-page story in *The Ottawa Citizen* on Tuesday, Nov. 21, 2000, by reporter Ian MacLeod. The front page screamed the headline "Ethics lessons rob surgeons of scalpel skills."

In the *Canadian Journal of Surgery*, from which MacLeod is quoting, Waddell argues rightly for the need to learn the skills of surgery “hands on.” In the last paragraph, he points out the competing demands on a resident’s time and advises those in charge of training to lobby the Royal College of Physicians and Surgeons of Canada to stop “increasing demands for didactic teaching in nonclinical areas such as ethics and communication, which are much better learned by direct observation of role models in the clinical setting.”

Wouldn’t it be nice if we lived in a world where ethics and communication skills were modelled by direct observation of role models? Sadly,

and based on the facts, we still need to teach it.

Reporter Ian MacLeod has sensationalized the discussion. MacLeod misses the point about “didactic” versus practice-based teaching. Dr. Waddell himself does not disagree with learning ethics and communication skills, he states later in the editorial. He concedes there might be some advantages for a patient if the surgeon has learned communication skills.

What might be argued is the means to that end. Dr. Nadia Mikhael, the director of education for the Royal College, confirms in *The Ottawa Citizen* article that it is the surgeons themselves who are responsible for training surgical residents and

who have identified the importance of teaching communication skills and ethics during surgical training. There is absolutely no argument over the fact that new trainees need to learn ethics and communication skills and that this should occur early in their training. Why would such a headline make the front page a newspaper such as *The Ottawa Citizen*?

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## CLINICAL PRACTICE GUIDELINES FOR THE CARE AND TREATMENT OF BREAST CANCER



In February 1998 *CMAJ* and Health Canada published 10 clinical practice guidelines for the care and treatment of breast cancer, along with a lay version designed to help patients understand more about this disease and the recommended treatments. These guidelines are currently being revised and updated, and the series is being extended to cover new topics. The complete text of the new and updated guidelines is available at *eCMAJ*:

[www.cma.ca/cmaj/vol-158/issue-3/breastcpg/index.htm](http://www.cma.ca/cmaj/vol-158/issue-3/breastcpg/index.htm)

### REVISED:

Guideline 7. Adjuvant systemic therapy for women with node-negative breast cancer [Jan. 23, 2001]  
Guideline 8: Adjuvant systemic therapy for women with node-positive breast cancer [Mar. 6, 2001]

### NEW:

Guideline 11: Lymphedema [Jan. 23, 2001]