

ties in nicely with the final chapter in the book, examining immunotherapy and gene therapy.

The second section covers particular clinical scenarios, including relatively common situations such as use of neoadjuvant chemotherapy, treatment of local-regional tumour recurrence and nipple discharge as well as the more uncommon management problems of breast cancer in pregnancy, axillary metastases with an unidentified breast primary, and uncommon primary breast tumours such as sarcoma and lymphoma. These topics are all well covered in an organized and comprehensive man-

ner. I found this section to be the most valuable and very easy to read.

The final section comprises 5 chapters that look at current controversies and research. The first of these is a well-balanced discussion of the use of breast conservation without radiotherapy. The next 2 chapters are particularly relevant to the emergence of sentinel lymph-node biopsy: one reviews the use of axillary dissection in breast cancer; the second covers the diagnosis and management of internal mammary nodal metastases. The final 2 chapters relate to the use of high-dose chemotherapy and novel gene thera-

pies. These are well written and complement earlier chapters.

Generally, this book is a positive contribution to the ever-burgeoning library on breast cancer. I would like to have seen a chapter reviewing hereditary breast cancer, including risk-reduction strategies. The book is well referenced, concise and easy to read, and I believe will be of value to many different practitioners, including physicians in training.

Ethel L. MacIntosh, MD
Medical Director, Breast Screening
Health Sciences Centre
Winnipeg, Man.

SESAP Critique Critique SESAP

Category 13, item 1

Endoscopic ultrasound (EUS) is superior to computed tomographic (CT) scanning for detecting the T and N stage of esophageal tumors. Not only can lymph nodes in proximity to the tumor be assessed, but also the celiac nodes can be assessed and biopsy specimens obtained. EUS is also useful in detecting pancreatic malignancies. With the endoscope in the stomach and duodenum, EUS is very sensitive in detecting pancreatic tumors both in the head and body of the pancreas with sensitivities greater than 90%. Differentiating inflammatory lesions from those caused by malignancy is difficult because their ultrasonographic characteristics are similar. As regards staging pancreatic tumors, EUS is more sensitive and specific than CT scan in detecting involvement of major vessels such as portal vein, celiac axis, and splenic vein. EUS is at least equal to CT scan at detecting the lymph nodes and may not be quite as good as CT scan in detecting hepatic metastases. However, EUS is more sensitive and specific than is CT overall for staging of pancreatic tumors, although it has the disadvantage of being operator dependent.

D

References

1. Faigel DO, Ginsberg GG, Bentz JS, et al: Endoscopic ultrasound-guided real-time fine-needle aspiration biopsy of the pancreas in cancer patients with pancreatic lesions. *J Clin Oncol* 15:1439-1443, 1997
2. Reed CE, Mishra G, Sahai AV, et al: Esophageal cancer staging: Improved accuracy by endoscopic ultrasound of celiac lymph nodes. *Ann Thorac Surg* 67:319-322, 1999
3. Rosch T, Braig C, Gain T, et al: Staging of pancreatic and ampullary carcinoma by endoscopic ultrasonography. Comparison with conventional sonography, computed tomography, and angiography. *Gastroenterology* 102:188-199, 1992
4. Rosch T, Lorenz R, Braig C, et al: Endoscopic ultrasound in pancreatic tumor diagnosis. *Gastrointest Endosc* 37:347-352, 1991