after self harm found little evidence for effective interventions.⁸ However, the main reason is methodological: there were few trials, and many of those reviewed were too small and were undertaken with selected subgroups of patients.

Why should it be so hard to enrol people who self harm into trials? Potential participants are usually distressed, sometimes angry, and almost always in crisis, factors which greatly hamper explaining the process of randomisation, establishing clinical equipoise, and obtaining consent. Carter and colleagues used a Zelen randomisation method, in which people are randomised before consent is obtained.⁹ The subsequent conversation with potential research subjects is therefore far easier, as they are offered only the choice of consenting to one intervention or not. Some research ethics committees still take the view that Zelen designs are unethical, but a conventional random allocation design in Newcastle would probably have resulted in a severely underpowered trial—which is itself unethical.

Why might postcards work, and would they be useful elsewhere? People who repeatedly harm themselves often have a morbid fear of being abandoned, so they may respond to an intervention that shows that they have not been forgotten. As well, postcards may make people feel more engaged by the service. We understand engagement as the process of understanding the meaning of an episode such as self harm in the context of the person's life story and agreeing on what to do about it. Engagement at the assessment interview in hospital is a neglected area of research in psychological medicine and consequently receives little attention in clinical practice guidelines on self harm. Staff need the right attitudes and assessment skills to achieve engagement, and patients should be seen in privacy where they can sit, rather than lie down. Having services dedicated to the management of self harm, as in Newcastle, probably increases the likelihood of engagement.

This study confirms that services for people who deliberately harm themselves should measure what

they do, pay attention to engagement, and offer aftercare. Even simple things should make a difference, such as systematically checking patients' contact details to ensure that the hospital has the correct telephone numbers and addresses, often those of families as well as patients. Really effective treatment may need face to face interventions, but this new evidence indicates that there may be a subgroup of people who are helped by regular contact through the mail. In future, text messages to mobile phones or emails might be tested, but, for now, snail mail seems to work.

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An adequate margin of excision in ductal carcinoma in situ

2 mm plus radiotherapy is as good as a bigger margin

The widespread use of mammography screening has led to a change in the perceived pathology of breast cancer. The increased detection of asymptomatic disease has resulted in an increased incidence of ductal carcinoma in situ (DCIS), which now accounts for about 20% of all cases of breast cancer. In addition, the past decade has seen a change in the management of primary breast cancer, from mastectomy to breast conservation where possible.¹ Clearly surgical management of DCIS poses several challenges, none more so than what should be the width of an adequate margin of resection. What is at issue is the size of the margin that ensures no residual tumour cells while minimising the deformity of the breast.

The National Surgical Adjuvant Breast and Bowel Project (NSABP) regards "no tumour cells on the

ink"—that is, a minimal margin free of disease—as a negative margin. Yet in a recent survey of 1137 radiation oncologists only 45.9% of North American respondents and 27.6% of Europeans agreed with this definition.² When this margin was extended to 2 mm over 75% of North American respondents agreed that this could be regarded as negative, while 51% from the United Kingdom continued to disagree that this margin was adequate.

A clear definition of the pathological growth behaviour of DCIS has helped to define what may be an acceptable margin of resection. Faverly et al have described a technique to define the three dimensional structure of the breast glandular tree and they have then used this to identify DCIS spread and multifocality.³ Using this technique to visualise DCIS, 90% of

poorly differentiated disease has a continuous growth pattern, in contrast to well differentiated lesions, where there is a multifocal pattern in 70% of cases. However, even in patients with discontinuous growth, 82% of gaps between areas of DCIS are less than 5 mm. Thus surgical excision of DCIS with margins of 5 mm free of disease seems unlikely to leave DCIS in the breast, and smaller margins may be appropriate for poorly differentiated DCIS.

From examination of re-excision specimens in patients with DCIS it is evident that the likelihood of further disease is related to the resection margin. Residual disease has been found in 85% of patients in whom DCIS affected the primary resection margin, 41% where the margin was 0-1 mm, and 31% where the margin was 1-2 mm, though no patients with margins 2 mm or greater harboured residual disease.⁴ In addition, Silverstein et al have shown no significant difference in the rate of ipsilateral breast cancer recurrence in patients with DCIS treated with breast conserving surgery and radiotherapy between those with margins greater than 1 cm and those with margins of 1 mm to 1 cm.⁵ Clearly the only benefit in taking a large margin free of disease—that is, more than 1 cm—could be in low risk patients in whom radiotherapy may be avoided, though the only reported study to investigate this failed to validate this treatment regimen.⁶

The Van Nuys prognostic index was developed as a potential scoring tool to estimate the risk of recurrence based on margin status, grade, and tumour size, which could then be used to plan treatment.⁷ This system was developed from a large cohort of patients with DCIS and then applied to a retrospective subset for validation. It separates patients with DCIS into three clearly defined risk groups: suitable for treatment with excision only, excision with radiotherapy, or mastectomy. However, prospective studies have failed to validate the low risk of recurrence in patients from the favourable prognostic index group treated without radiotherapy.⁶

Several prospective studies have shown that radiotherapy reduces the risk of local recurrence after the surgical excision of DCIS. The B-17 trial of the National Surgical Adjuvant Breast and Bowel Project, a prospective, randomised trial investigating the role of radiotherapy on breast conserving surgery for DCIS, showed the eight year local recurrence rate of DCIS to be 13% among patients treated with excision plus radiation therapy and 31% among patients treated with excision alone.⁸ A similar benefit from radiotherapy has been reported in randomised trials performed by the European Organisation for Cancer Research and Treatment (EORTC) and the UK Coordinating Committee on Cancer Research.^{9 10} In the EORTC trial only negative margins were required, and margin width was specified in only 5% of cases. In spite of this, local recurrence was observed in only 9% of patients at 4 years.¹¹ The UK trial also specified no specific margin width as negative, and reported an 8% failure rate in patients receiving radiotherapy. Recent analysis of over 1000 patients from North America and Europe treated with breast conserving surgery and radiotherapy for DCIS indicates that a margin width of 2 mm combined with radiotherapy can achieve excellent local control.¹² In this study, negative margins were associated with local recurrence rates of 8% at 10 years.

Radiotherapy is currently the standard of care after breast conserving surgery in the treatment of DCIS; and there is no convincing evidence that larger margins confer better rates of local control.¹³ However, when large disease free margins are taken and more breast tissue is removed there is a greater deformity to the breast and patients will suffer a worse cosmetic outcome.¹⁴

On balance there is good evidence that surgical resection margins free of DCIS should be obtained. Current evidence suggests, however, that when radiotherapy is given the results are as good when the margin is at least 2 mm as they are when it is more than 1 cm. Finally it is important to keep in mind the extremely low risk of death due to breast cancer associated with a diagnosis of DCIS.⁸⁻¹² The intensity of the surgical debate on margins and local recurrence in DCIS has resulted in great confusion among patients about treatment choices and is causing patients to choose mastectomies that are not medically necessary.¹⁵

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