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We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

Tuberculosis of the breast

SIR,—The report by Dr M C P Apps and others (23 June, p 1874) usefully reminds us that tuberculous mastitis is a diagnosis often made overconfidently by those aware of the disease but unfamiliar with conditions that may mimic it. In over 30 years I have collected a series of 44 cases of caseating granulomatous mastitis, and in only six was tuberculous infection proved (table).

Perhaps a need to condense their paper prevented the authors from making the point that the diagnosis was proved in only two of their five cases. It is well known, and should be better known, that "histological findings typical of tuberculosis" are diagnostic only when *Mycobacterium tuberculosis* is isolated from the lesion or perhaps from matter obtained from the lesion. Even the microscopical demonstration of acid fast bacilli is not necessarily evidence of tuberculosis unless their identity is confirmed by their cultivation.

A standard work on mammary pathology notes: "It is worth remembering . . . the necessity of identifying tubercle bacilli in the lesions before interpreting granulomatous disease as tuberculous"; and another: "Not only biopsy findings but bacteriological verification is requisite for the diagnosis."² A clinician wrote in the context of tuberculosis of the breast: "Modern pathologists have come to realise that a great variety of granulomatous processes . . . produce microscopic pictures indistinguishable from tuberculosis."³ To ignore such experience is to risk danger to patients, and this should be in one's mind when thinking of entering a diagnosis of tuberculous mastitis in a patient's records and when preparing publications.

Even when tuberculosis is present in a breast

there is always a possibility that it is associated with another and perhaps even more serious disease, particularly cancer. Coexistence of proved tuberculosis and cancer in a breast is

very rare, but it is not so rare that the diagnosis of tuberculous mastitis may be regarded as excluding the presence of the other. No doubt the granulomatous condition in many of the

*Final diagnosis in 44 cases of caseating granulomatous mastitis initially diagnosed histologically as tuberculous (1947-83)**

Final diagnosis	No of cases	Geographical source of disease
Proved tuberculosis: <i>M tuberculosis</i> isolated	6	Hong Kong; India (2); Ireland; Pakistan; Scotland
Presumptive tuberculosis: <i>M tuberculosis</i> not isolated but acid fast bacilli present in histological sections or films of matter from lesion or both	5	England; East Africa (Asian woman); India (Scotswoman); Indonesia; Norway
Other proved infections:		
Tularaemia (following penetrating wound)	1	Germany
Syphilis (gummatous mastitis, with softening)	1	England
Lymphogranuloma inguinale (confined to breast)	1	India
Blastomycosis (<i>Blastomyces dermatitidis</i>)	1	Ethiopia
Chromomycosis (<i>Phialophora gougertii</i>)	1	India
Cryptococcosis (cryptococci not seen until third biopsy)	1	Scotland
Histoplasmosis (<i>Histoplasma capsulatum</i>)	1	Malaysia
Phycomycosis (<i>Conidiobolus coronatus</i>)	1	Malaysia
Sporotrichosis	1	Ireland
Metazoal infestation:		
Cysticercosis (<i>Taenia solium</i>)	1	India
Hydatid cyst (<i>Echinococcus granulosus</i>)	1	Pakistan
Pentastomiasis (<i>Armillifer armillatus</i>)	1	Malaysia
Iatrogenic:		
Mastoplasmy (injection of liquid or soft paraffin)	2	England; Thailand
Packing of cavity of true abscess with gauze impregnated with medicated soft paraffin	3	England (2); Sri Lanka
Endogenous granulomas:		
Complicating mammary duct ectasia; after aspiration/incision/rupture of milk cyst; after trauma	7	
Uncertain cause:		
Histological findings consistent with tuberculosis but no acid fast bacilli found and cultures (if any) yielded no pathogens; no evidence of any other condition; diagnosis therefore considered likely to be tuberculosis but with no bacteriological support	9	East Africa (2 Asian women); England; France; India (2); Ireland; Pakistan; Scotland

*Most of the patients were seen in Britain; about a third were seen in the course of visits to surgical pathology services overseas.

older reports of coexistent tuberculosis and cancer in a breast would today be regarded as a non-infective accompaniment of the tumour, but unquestionably there are occasional instances of proved tuberculosis in a cancerous breast (although of no statistical relevance, this association was present in two of the six cases of proved tuberculous mastitis in the table). It is essential to avoid mistaking the non-infective granulomatous reaction in a cancerous breast for tuberculosis or any other infective condition and so delaying diagnosis of the associated tumour.

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¹ Azzopardi JG. *Problems in breast pathology*. London, Philadelphia: W B Saunders, 1979:399.

² Bässler R. *Pathologie der Brustdrüse*. Berlin, Heidelberg: Springer Verlag, 1978:276.

³ Haagensen CD. *Diseases of the breast*. 2nd ed. London, Philadelphia: W B Saunders, 1971:335.

SIR,—Tuberculosis of the breast must always be borne in mind whether it presents as a painful inflammatory swelling arising over weeks or as a painless lump of short duration. Though Dr M C P Apps and others emphasise the Asian origin of their patients, my colleague Mr K Wilkinson and I described five cases of tuberculosis of the breast, in which only one was of overseas (Nigerian) origin.¹ A full description of tuberculosis of the breast in Nigerian subjects has been published by W W Davey.²

Though two of our own patients had no history or previous evidence of tuberculosis, and were considered to be examples of primary breast tuberculosis, the remaining three had long histories of tuberculosis at other sites: one had apical pulmonary tuberculosis, another had mediastinal and cervical lymph nodes, and the third suffered from lumbar spinal tuberculosis.

The important lesson to remember is the possibility of tuberculosis as a cause of breast swelling or abscess, especially when the pus is reported as being sterile on culture, when the abscess recurs, or when there is a persistent sinus.

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¹ McKeown KC, Wilkinson KW. Tuberculous disease of the breast. *Br J Surg* 1952;157:420-9.

² Davey WW. *Companion to surgery in Africa*. London: Livingstone, 1968:165-8.

Problems of tuberculosis in decline

SIR,—Dr N W Horne emphasises current problems of tuberculosis in Britain, especially difficulties of diagnosis and management of atypical presentations of this disease. One of our patients recently exemplified this.

A 34 year old white man was admitted to another hospital because of dizziness, weakness, anorexia, fever, recent night sweats, and weight loss. His only known contact with tuberculosis was at the age of 6 years when his father and brother were treated for tuberculosis and he had BCG. His main abnormal physical signs were fever, bilateral basal lung crepitations, and tender hepatosplenomegaly. A 1:1000 Mantoux test was negative, but he had pancytopenia, inappropriate antidiuretic hormone secretion, abnormal liver function tests, and "infective" changes on the chest radiograph. Suspected legionnaires' disease was treated with erythromycin with improvement.

Six days later his sputum showed acid and alcohol fast bacilli and he was transferred to this hospital and given intravenous hydrocortisone,

streptomycin, ethambutol, and modified doses of rifampicin and isoniazid because of abnormal liver function tests. He rapidly deteriorated over the next three days with the adult respiratory distress syndrome, and assisted ventilation was considered. Because only scanty acid and alcohol fast bacilli were found initially and pancytopenia persisted, we considered other infective possibilities including *Pneumocystis carinii* and staphylococcal pneumonia, and he was given intravenous cotrimoxazole and flucloxacillin as well as increased oxygen. He made a dramatic improvement probably because of improved oxygenation since apart from tuberculosis no other infection was confirmed.

Four days later his original bone marrow histological examination showed tuberculous granulomas, and further sputum was now strongly positive for acid and alcohol fast bacilli. Sputum and urine cultures yielded a fully sensitive *Mycobacterium tuberculosis*. He improved on standard doses of rifampicin, isoniazid, and pyrazinamide with normal haematological and biochemical parameters.

Disseminated disease with associated leucopenia or pancytopenia has always been regarded as a particularly malignant and often fatal form of tuberculosis.² Our hesitant diagnostic conviction and inadequate oxygen and chemotherapy nearly led to a fatal outcome. Yet the features he manifested are recognised in disseminated tuberculosis.¹ Concern over the multisystem nature of atypical pneumonias and opportunistic pulmonary infections should not blind us to tuberculosis with its protean manifestations.

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¹ Anonymous. Mycobacterial infections and leucopenia. *Lancet* 1981;iii:184.

The presentation of raised intracranial pressure in children with spina bifida and the importance of integrated follow up

SIR,—Increasing numbers of young adults with spina bifida and multiple disabilities are leaving the integrated care of their paediatric departments for the fragmented care of adult units. They are faced with difficulties of obtaining new crutches and wheelchairs, and knowing where to go with urinary problems, persistent pressure sores, and possibly blocking valves. Mr A M K Rickwood and others (2 June, p 1677), illustrating one aspect of these problems, state that those with congenital neuropathic bladders need lifelong urological supervision.

Of equal importance to the need for urological surveillance is the need to look for hydrocephalus. In the past six years, as medical officer to Lord Mayor Treloar College for physically handicapped children, I have been responsible for the primary medical care of 142 children with spina bifida, 103 of whom have valves controlling their hydrocephalus. The valves were inserted in infancy, and many had several operations on their valves in the first two years. From three to 18 years there was a consistent need, ranging from 4-13% of children, to have valve operations each year. Does this incidence of valve malfunction continue after the age of 18 years?

In these children valve malfunction presents

in a variety of different ways and seldom shows the classical picture of raised intracranial pressure with headache, vomiting, drowsiness, and papilloedema. I have seen 34 children with raised intracranial pressure due to valve malfunction, and their presenting symptoms have been: headache (19), vomiting (7), drowsiness (7), unconsciousness (4), fits (3), pain over meningomyelocele scar (2), and educational deterioration (8).

Eye changes—for example, new nystagmus, new squint, or reduced visual acuity—occurred in six children, and early papilloedema in only three children. Five children presented with educational deterioration only; the diagnosis was confirmed by brain scan or ventriculomanometry, and raised intracranial pressure was found at operation. Three more children had deteriorating educational function in association with intermittent headaches, again found to be due to the insidious onset of raised intracranial pressure. In my experience, the more aware the school is of the importance of academic deterioration in these children the earlier the signs of a slow rise in intracranial pressure can be found and treated.

It will be difficult for adult neurological units to take over the care of this unusual group of children with hydrocephalus without close cooperation with the paediatric surgeons who have known them since birth. There is an urgent need for integrated medical follow up for the increasing number of adults with spina bifida, who have the added disadvantage of being less intelligent than they appear and who are relatively unmotivated to help themselves.

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Antismoking interventions in general practice

SIR,—Dr Konrad Jamrozik and others (19 May, p 1499) confirm previous evidence¹ that advice by general practitioners can be important in reducing the number of smokers in the community. How can the results of short term trials, where all smokers are given advice, be related to everyday general practice?

In the winter of 1981-2 we carried out a monitoring exercise in 10 group practices in the Edinburgh area for one week before and two weeks after the launch of the Give Up Smoking kit. A further two week monitoring was carried out during the subsequent BBC series on giving up smoking. Doctors were asked to record the name and presenting condition of each patient with whom they discussed giving up smoking. The aggregated weekly advice giving rates for the 10 practices (which care for a total of some 100 000 patients) were 199, 111, and 93 over the three successive periods. In 21% of cases the advice had been solicited by the patient. There was no evidence of an increase in advice given by GPs with the launch of the kit but rather a suggestion that the monitoring exercise produced a brief initial spurt of activity. There was, however, other evidence that the kit did engage the interest of GPs. All 2959 GPs in Scotland were sent a sample of the kit and asked to post in requests for further copies. Some 781 (26%) did so, and it was estimated, on the basis of a 10% follow up survey, that these requests were on behalf of 73% of Scottish GPs.

Patients who had been given advice during the monitoring exercise were followed up by post one year later in nine of the 10 practices. There were 270 replies (53% of the total of 535 less 27 "gone away"). Of those replying 37 stated that they had stopped smoking (14% of replies and 7%