Reply

Dear Sir,

I am grateful for the reader's comments. In regards of the queries raised in the ibid letter, I have the following to submit:

It is clarified that Oncoplasty Breast Surgery actually encompasses, both volume displacement (local breast flaps) as well as volume replacement (distant autologous tissue) techniques. Though in common understanding, readers associate the term only with the former. In this regard, some excellent reviews are available for perusal.^{1,2}

MR mammography was not employed as a routine in all cases but digital mammography was used in all cases.

It is agreed that breast cancer in younger patients is considered a more aggressive entity. But this is attributed to tumour biology per se (ER/PR negative, Her2Neu positive, high grade, extensive DCIS etc). Contrary to the traditional teaching, breast conserving surgery is feasible every time it is judged possible to achieve complete surgical excision with good cosmesis. The size of the tumour relative to the breast volume is the deciding factor in determining the suitability of breast conserving surgery. It may even be suitable for women with large breasts in whom the tumour is up to 5 cm or even multifocal tumours confined to the same quadrant and when large operable tumours have been down-staged by neoadjuvant chemotherapy. Younger age of the patient is not a contraindication.

Authors have used technique of tattooing the tumour margins on the skin prior to initiating neoadjuvant chemotherapy. This helped in tumour localisation prior to surgery.

It is agreed with the reader that positive margins after OBS would entail a need for completion mastectomy. However, with techniques of OBS it is possible to obtain wider margins than standard BCS alone and yet achieve good cosmesis. Hence, the authors' have not encountered involved or close margins in their series as yet. The authors' aim for minimum of 1 cm clear margin during resection.

It is agreed that lobular carcinomas tend to be multicentric hence may result in positive margin on histopathological examination of the BCS specimen. However, a pre-op tissue

diagnosis of lobular carcinoma is not a contraindication to BCS. The caveat we follow is a judicious study of pre-op mammogram in conjunction with our radiology colleagues to look specifically for multifocality and multicentricity in these cases.

The present paper aimed to present the good cosmetic results obtained in patients offered OBS. These patients are under follow-up and final oncologic results will be seen over the period of time. In this regard attention is drawn to published literature which has addressed precisely this issue.³

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Letter to the Editor

Dear Editor,

I read with interest the article titled “Cross sectional assessment of empathy among undergraduates from a medical college” by Shashikumar R et al. published in *Med J Armed Forces India* 2014; 70:179–185. The author has brought to light a problem that has seemed to be set medical education in the West for many years – the slow decline in empathy throughout medical school.¹ One potential weakness of the study was that it was cross sectional. A better style of study might be a longitudinal cohort study – where students were followed from

their first year of medical school to their last. Such a cohort study would be challenging – not least because of the amount of time and expense that would be required to run it properly. Inevitably there would be some loss to follow up among participants and such loss to follow up might be differential – perhaps with some students who were outliers in terms of empathy levels being more likely to leave their course and/or fail their exams. However the validity and reliability of the results of a cohort study would probably make the time and expense necessary to run it worthwhile in the end.