Sir,

Carcinoma of the breast is the commonest malignancy in females all over the world and second leading cause of death due to cancer among females. In Pakistan, it is more common at a young age contrary to the West where it is more common after 60 years. All women regardless of their racial or ethnic origin or heritage are at risk of developing breast cancer. Key factors among those that affect breast carcinoma development, are the roles of genetics and environment, the reproductive experience, the effect of endogenous and exogenous hormones in females, the change in immune status, host vulnerability, and the biologic determinants of breast carcinoma.

Approximately one in every nine Pakistani women is likely to suffer from breast cancer. This is one of the highest incidence rates in Asia. Pakistani women show an incidence rate of 50/100,000 and in the neighbouring country India, with similar socio-cultural background the incidence rate is 19/100,000. The pattern of rapid pre-menopausal increases in breast cancer is also seen in Pakistan, but breast cancer risk plateaus after the age of 45 years.

Locally advanced breast cancer (LABC) which is also a common presentation includes non-metastatic tumours larger than 5 cm in diameter or that involve skin or chest wall. These also include tumours associated with fixed axillary lymph nodes and with ipsilateral supraclavicular, infraclavicular or internal mammary nodal involvement. The disease burdens of cancer are rarely considered for developing countries like Pakistan. The South Karachi Cancer Registry suggests that the age-standardized annual rate of breast cancer in Pakistan is 69.1 per 100,000, a figure equivalent to European and North American rates. In fact, Pakistan's population boasts the highest rate of breast cancer amongst all Asian countries (excluding Jews in Israel) as, over 90,000 women suffer from breast cancer annually.

This study was carried out at Gujranwala Institute of Nuclear Medicine and Radiotherapy, Gujranwala (GINUM). Patients who were registered with diagnosed breast cancer at hospital for the first time were studied. Records of all the breast specimens including mastectomy, lumpectomy and needle biopsy in the GINUM and outside referrals were included. Oncology history form was used to collect data.

Data showed that the patients presented at GINUM were mostly belonged to the younger age group and it was more in the poor and middle class and more in multiparous women than nulliparous. Mammogram patterns showed late presentation of women when the size of tumour was more than 2 cm. One-third patients suffered inadequate surgery i.e. inadequate due to positive margins. Due to these positive margins, either patients were sent to repeat surgery and if it was not possible they were subjected to radiotherapy. Only 10% agreed for re-surgery due to economical or performance status issues. The incidence of intraductal variety of carcinoma with trends towards the high grade was seen among patients. Ratio of women with high grade intraductal carcinoma was also high. Twenty percent patients presented with lump size less than 2 cm and (80%) patients presented with lump size more than 2 cm. The number of patients presenting with nodal metastases was also high. More than 36% of females presented with nodal metastases. Due to nodal metastases, the stage of presentation was also high which reduces the life expectancy. Early stage presentation was another factor contributing to the high risk hormone negative status. A comparison of this study with other national and international studies showed good relevancy with results, however, the study region showed some drastic results with reference to carcinoma breast prevalence in younger age group.

It is suggested that:
1. Aggressive screening and awareness programs should be arranged.
2. Risk factors predisposing to high incidence of carcinoma breast should be identified and dealt with.
3. Female literacy regarding lumps in the breast should be increased.
4. Combined CME should be arranged with surgeons to adopt protocols, which lead to once only surgery protocols and multidisciplinary approach to patient management.
5. Younger age group in the colleges and schools should be trained for breast self-examination (BSE).
6. Media should be used to increase awareness among general practitioners.
7. All concerned people like Hakeems, Homeopaths should be provided awareness for early referral of such patients to the tertiary hospitals.
8. NGOs should be utilized to increase awareness programs.
9. Central cancer registry program/system should be introduced by Government to monitor cancer registry.

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Letters to the editor


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Congenital Pubic Sinus: Clarified Nomenclature

Sir,

Congenital prepubic sinus (CPS) is a rare anomaly of the urinary system, typically observed in front of the pubis as a dead-end sinus with a small opening. Fifty cases have been reported since the first report by Campbell et al. in 1987.1-6 With a still-debated embryologic origin, this anomaly also has diverse nomenclature in the literature, being referred to as a subpubic fistula, suprapubic dermoid sinus, penopubic sinus, and suprapubic urachal sinus.1-6 We have reported 2 cases of this rare anomaly previously.6 Herein, we report the third case, and propose a specific terminology for future use.

A 10-month-old baby boy with anal atresia and penile rotation was admitted for treatment. Physical examination revealed anal atresia with colostomy and 90-degree clockwise penile rotation with partial preputial agenesis. Laboratory findings were normal. A voiding cystourethrography and urinary tract ultrasonography were normal. During penile reconstruction, a 2 cm sinus in the dorsal penis was discovered (Figure 1). The dead-end fistula extended to the pubis but was delineated by filling it with methylene blue via a 24G cannula, allowing complete excision without difficulty. Pathologic examination revealed a sinus tract lined by multi-layered squamous epithelial cells. The patient was discharged on the 6th postoperative day without complication and a 2-year follow-up period was uneventful.

CPS is a very rare malformation of the urinary system.1-6 The anatomic and pathological characteristics of this lesion with various names are well defined, but its etiology is still debated.1-6

Clinical examination is useful in detecting CPS,3,6 but ultrasonography and other urinary system imaging techniques may not be helpful in diagnosis.3 Conversely, fistulography is useful for observing the extent of the lesion and its communication with the urinary system.3,6 In our first 2 cases, no connection was observed between the defect and the urinary system on anteroposterior and lateral fistulography.6 However, because the current case was diagnosed during penile reconstruction, we preferred to stain with methylene blue; this revealed no communication of the lesion with the urinary system. We believe that lateral and anteroposterior fistulography should be performed to anatomically delineate the lesion. Intraoperative staining with methylene blue proved useful for defining the surgical borders and dissection line.3,6 Our previous cases had no further anatomical abnormalities, whereas the current case also had penile rotation and anal atresia.

The CPS of all cases was interpreted as a dorsal urethral duplication (Stephens Type 3), as no connections with the urinary system were detected. Despite complex etiology and nomenclature, the anatomy and pathology of the CPS are increasingly defined.1-6 The localization of the CPS, which begins at the pubic area and is in close proximity with the pubic bone, has also been

Figure 1: The congenital prepubic sinus (arrow) of the case with penile rotation was excised without difficulty by filling it with methylene blue.
referred to as suprapubic, subpubic, or penopubic. Nevertheless, we believe that it would be adequate and correct to name it simply a 'congenital pubic sinus' to minimize confusion in identification. Regardless of the tract from which it may have arisen, a complete excision of the sinus is required, as it may become symptomatic and potentially malignant later in life. These lesions can be easily and completely treated by simple excisions.

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