

Management of Nonparasitic Hepatic Cysts

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We congratulate Mazza and colleagues¹ for a comprehensive article on their 17-year experience treating nonparasitic hepatic cysts (NPHC). Although some mention was made of malignant cystic neoplasms in their reference to the use of tumor markers in the diagnostic workup, as well as the radiologic appearance of irregular, thickened cystic walls, we feel that this important component of cystic hepatic lesions was not sufficiently emphasized. After all, the title of the article is "Management of NPHC," and the consequence of missing a malignant lesion can be catastrophic. Intrahepatic biliary cystadenoma (IBCA) is one of the most common premalignant cystic hepatic lesions, accounting for approximately 5% of all symptomatic cystic lesions.² The typical ultrasonographic feature of an IBCA is that of a solitary, multiloculated cyst; whereas the computed tomography scan appearance reveals thin, internal septae.³ Magnetic resonance imaging shows gadolinium enhancement of the septae.⁴ Elevated levels of CA 19-9 in the cystic fluid has also been shown to differentiate between benign and malignant lesions.⁵ It would therefore be quite interesting to know the radiologic features of the 7 patients diagnosed with cystic neoplasms by Dr Mazza and his team and what specific measures they would recommend to exclude malignancy prior to embarking on definitive management.

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Reply

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We would like to thank Drs Maharaj, Naraynsingh, and Shukla for their comments; their letter represents a useful complement. Malignancy and pre-malignancy need to be excluded in NPHC. We diagnosed 7 cases in our series that were not included in this study; despite their exclusion from the analysis they have been thoroughly addressed in the "Methods" section (page 733) and "Discussion" section (page 738) of our manuscript. Malignancy was suspected in cases of cystic wall thickening or papillary growth within the cyst. Contrast-enhanced computed tomography scans combined with MRI and alfa-fetoprotein, CEA, and CA 19-9 serum levels were used for preoperative diagnoses. Oncologic resections were based on intraoperative findings. When in doubt, intraoperative ultrasonography and frozen examination of surgical specimens is recommended. If a malignant diagnosis is confirmed, complete resection of the lesion with oncologic margins is required whenever possible. Outcomes depend on the type of tumor present.

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Lumpectomy and Cavity Shaving

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Blair and colleagues¹ discussed the very controversial issue of standard of care for stages I and II (T1 and T2) breast carcinoma in their article, with reference to cavity shaving, frozen-section analysis (FSA), imprint cytology, re-excision of the cavity, tumor-bed shaving, and negative margin. As a retired oncologic surgeon with a special interest in surgical treatment of breast malignancy, and one who has had the opportunity to work as a consultant surgeon in the United States, United Kingdom, New Zealand, and Australia, I am surprised to see that majority of surgeons do not perform cavity or bed shaving of the lumpectomy cavity. Only 48% of surgeons who do cavity and bed shaving of the lumpectomy cavity examine the cavity shaving margin grossly with the pathologist, very few do FSA or imprint cytology, and 57% never re-excite with positive margin. The current standard of care for early breast cancer is minimally invasive breast biopsy to establish diagnosis;