



LETTERS / CORRESPONDANCE

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RING REMOVAL

To the Editor:

I read with interest the article on ring removal in the Winter 2010 issue of the *Canadian Journal of Rural Medicine*.¹

While working as the medical officer on a Canadian survey ship, I removed a ring from an injured crew member. The ring had been made from a hardened steel ball bearing race, so it could not be cut with a conventional ring cutter. The crew member had short-circuited a battery bank through a wrench into his ring. The heat from the current had vapourized a section of the ring and had caused a third-degree burn on the underlying skin. The dramatic tissue swelling threatened to cause an acute ischemic injury, and we were several hundred miles offshore at the time.

The ring was removed using a small hand-held inexpensive hobby tool called a "Dremel Moto-Tool." Generic variations of this tool are widely available. The attachment used was a thin abrasive disc less than a millimetre thick, which easily cut through the hardened steel.

This technique proved to be quick and was easily performed. Caution does need to be exercised to prevent thermal injuries from the cutting disc. Also, the cutting disc is thin and fragile so the operator should wear safety glasses.

Bruce Woodburn, MD, FRCS(C)
Sechelt, BC

REFERENCE

1. Baker A, Rylance K, Giles S. The occasional ring removal. *Can J Rural Med* 2010; 15:26-8.

SCREENING MAMMOGRAPHY

To the Editor:

The recent article by McDonald and Sherman¹ about determinants of mammography use was interesting. I am concerned, however, by their recommendations for information campaigns to "boost compliance" in rural areas and for more use of mobile mammography clinics.

A screening mammogram does not save a woman from dying of breast cancer. Rather, it succeeds if, by initiating a cascade of tests, treatments and follow-ups, a cancer that would have been lethal if detected later, is found and cured. Unfortunately, this cascade is easily triggered, and the positive outcome is rare.

Of women enrolled in a screening mammography program, 99.9% will not benefit; many will be harmed. A recent editorial in the *BMJ* states, "For every 1000 women undergoing annual mammography for 10 years, 1 woman will avoid dying from breast cancer, 2–10 will be overdiagnosed and treated needlessly, 10–15 will be told they have breast cancer earlier than they would otherwise have been told, but this will not affect their prognosis, and 100–500 will have

at least one 'false alarm' (about half of these women will undergo a biopsy)."²

For rural women, each "false alarm" will require travel to a larger centre; those women unfortunate enough to be overdiagnosed will have dozens of needless trips over several years. Added to the fears and risks all women are exposed to from screening mammography, rural women and their families must also contend with significant expenses, increased risk of injury from motor vehicle collisions, and leaving their work and other responsibilities for much longer periods than their urban counterparts.

The farther away from an urban centre a woman lives, the greater the potential negative impact of screening mammography, even if the initial screening is done by a reliable mobile clinic in her hometown. Any information campaign should honestly disclose the risks and benefits of screening and respect the decisions of those who choose not to be screened.

Shelagh McRae, MD, CCFP, FCFP

Gore Bay Medical Centre, Gore Bay, Ont.

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1. McDonald JT, Sherman A. Determinants of mammography use in rural and urban regions of Canada. *Can J Rural Med* 2010; 15:52-60.
2. Welch HG. Overdiagnosis and mammography screening. *BMJ* 2009;339:b1425.

[One of the authors replies:]

The current recommendation of the Canadian Cancer Society, Health Canada and the US Preventive Services Task Force is that asymptomatic women aged 50–69 should undergo biennial mammography screening for breast cancer.^{1–3} The US National Cancer Institute's current recommendation⁴ is for biennial mammography screening beginning at age 40, though this recommendation is being reviewed based on mixed evidence about the efficacy of mammography screening for women aged 40–49.

We certainly agree that it should be the case that recommended guidelines for any form of asymptomatic screening be reviewed periodically to ensure that they reflect best practice and current research. However, the purpose of our paper⁵ was not to evaluate these guidelines. Rather, we sought to examine the extent to which rural- and urban-dwelling Canadian women are compliant with the currently accepted recommendations regarding mammography screening and to consider possible reasons for any observed differences.

Our analysis indicates that an important reason why rural women aged 50–69 have lower compliance with recommended guidelines is not access barriers, but rather differences in the attitude of rural women about the importance of regular mammography screening. Because these guidelines have been in place for years, we do see our results as evidence that efforts to communicate information on the importance of regular screening may have been relatively less effective in reaching rural women, and this may well generalize to other forms of screening.

Furthermore, we do not specifically advocate for the increased use of mobile mammography clinics in rural areas, but rather suggest that the increased use of mobile mammography clinics in rural areas should be “accompanied by efforts to increase awareness of the importance of mammography screening among women living in those areas.” Without an effective information dissemination campaign, efforts for increasing cancer screening to recommended guidelines, *whatever those guidelines are*, may not prove to be very effective.

We also strongly agree with

Dr. McRae's concluding statement that “any information campaign should honestly disclose the risks and benefits of screening and respect the decisions of those who choose not to be screened.” Our results suggest, however, that it may be relatively more difficult to communicate effectively any information on mammography screening, including risks and benefits, to women living in rural and remote areas.

James Ted McDonald, PhD
Fredericton, NB

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1. Canada Cancer Society. Breast cancer. Available: www.cancer.ca/Canada-wide/Prevention/Getting%20checked/Breast%20cancer%20NEW.aspx?sc_lang=en (accessed 2010 Sept. 2).
2. Health Canada. Mammography: It's your health. Available: www.hc-sc.gc.ca/hl-vs/iyh-vsv/med/mammog-eng.php (accessed 2010 Sept. 2).
3. U.S. Preventive Services Task Force. Screening for Breast Cancer. Available: www.uspreventiveservicestaskforce.org/uspstf/uspstfbrca.htm (accessed 2010 Sept. 2).
4. National Cancer Institute. Breast cancer screening. Available: www.cancer.gov/cancer-topics/pdq/screening/breast/healthprofessional (accessed 2010 Sept. 2).
5. McDonald JT, Sherman A. Determinants of mammography use in rural and urban regions of Canada. *Can J Rural Med* 2010; 15:52-60.

Correction

The authors of “Recruitment trumps retention: results of the 2008/09 CMA rural practice survey”¹ have indicated that a correction is in order. On page 106 at the top of the first column, “Given that the survey results showed that 14% of rural physicians intended to leave rural Canada within the next 2 years ...” should read “Given that the survey results showed that 14% of rural physicians intended to leave their communities within the next 2 years ...”.

REFERENCE

1. Chauhan TS, Jong M, Buske L. Recruitment trumps retention: results of the 2008/09 CMA rural practice survey. *Can J Rural Med* 2010;15:101-7.