Reviewer's report

Title: The accuracy of frozen section analysis in ultrasound-guided core needle biopsy of breast lesions

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Reviewer: Charles Cox

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ou must pardon my inability to handle the British language,
P 3 line 1 programmes, line 4 percutaneus,
P 6 line 8 gynaecologic,
P 7 line 3 postmenopausal ; praemenopausal ; last line There were no.., should read There was no further discordance.. .
P 8 line 2 dignity ??? I do not have a clue what is implied by this comment.
P 8 line 5 In an univariate ... should read, In univariate analysis... .
P 9 line 17 Using a comparable obtaining procedure... should read, Using a comparable procedure... .
P10 line 2 could not find out tumor or patients characteristics, better stated, could not demonstrate any clinical of pathologic criteria, which were significantly related.
P 11 line 1 tumor marker performing. (Awkward needs to be rephrased cannot understand the statement)
P11 last line guidance is always warranted. Would state it guidance is warranted.
P12 last line lesion, should be lesions

The paper would benefit from a flow diagram to follow the numbers. From the manuscript the numbers do not add up. 59 F/S cases (38+) (21 -) but 2 of the 21 were non committal by the pathologist and 2 were false negative. 61 perm presume (29 +) (or is it (27 +) with the 2 false negatives?) and( 32- ) The total of 67 positive (does that include the 2 false negatives?? ) or is it 69?? Are the true negatives 21 in the F/S group or are they 19 minus the 2 false negatives? Get my point it becomes very hard to follow the numbers and understand where they end up in the calculations.

Since none of the clinical pathologic findings were significant one could exclude all those tables and make the statement that all those were analyzed and were not significant. That I understand is a European thing to put all the data in the
manuscript and on an electronic journal what's a few more pages of trivial, pedantic and irrelevant data?

Aside from my personal bias regarding negative data, this is a very nice summary of the relatively small data set of 59 patients with F/S biopsy of core samples and bears publication with an understanding that with a larger series the data may change considerably. It is a good feasibility paper and brings out the point that the patient needs to have the information quickly and accurately and that this accomplishes that to a greater or lesser degree. As a matter of practice it was sad to see that this did not lead to faster definitive surgical care and that it was thwarted by some notion that the patient had to undergo an obligatory metastatic survey prior to definitive surgical care. This is a practice that is not done on the lesser side of the ocean. Key staging information of node positivity and local control take precedent over bone, lung and liver scans and if the patient is found to have metastatic disease later it has been shown that local measures of care result in improved survival of metastatic patients. So why are these patients being delayed to surgery and who is responsible in your system for this? They need to be informed and they need some sensitivity training as to the patients fear and concern of having a tumor residing in their body. There are some excellent studies of the anxiety level of the diagnosis of breast cancer and the delay in diagnosis and treatment that you address and should be a major reason for the publication of this data.