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IAN FENTIMAN and Richard Epstein's commentaries on routine axillary node dissection (RAND) make excellent reading. I found myself totally convinced by the arguments first of one, then of the other, and was left wondering whose point of view would get my 'vote' at the end of a well argued debate. The arguments in favour of RAND are that it is a simple surgical procedure which provides excellent local tumour control with minimal morbidity, that it provides important staging and prognostic information, and that the alternative 'watch policy' may increase the risk of uncontrollable axillary recurrence and possibly even have an effect on overall prognosis. The arguments against are that axillary irradiation provides comparable rates of local tumour control to axillary surgery, and that decisions regarding adjuvant systemic therapy can be made without a knowledge of axillary node status. What are busy clinicians reading this Journal going to do with the conflicting information and views given to us?

The most contentious area in this debate is whether or not untreated nodal involvement might have an adverse effect on survival. The general consensus from randomised studies is that survival is broadly similar with or without RAND. Nevertheless, I think that this question is one about which there is still lingering doubt. It may well be that there is a subgroup of patients for whom ineffective local treatment may result in long-term survival disadvantage as argued by Harris and Osteen [1], Stotter and colleagues [2], and in Haagensen's experience of Halsted mastectomy [3] showing long-term survival of patients with multiple involved nodes despite the absence of any systemic therapy at all. This issue becomes increasingly important given the rising number of screen-detected cancers being treated by Specialist Breast Units. The rate of axillary node positivity for incident round screen-detected invasive cancers is little different to that for symptomatic breast cancers, and in aiming to give these patients long-term survival, it is important that we are not tempted into under treatment.

Regardless of any effect on survival, an important role of the team treating the primary breast cancer must be to achieve local control—either by surgery or radiotherapy to the axilla. A 'watch policy' reserving treatment in the event of axillary recurrence is, in my view, not an acceptable option because of the devastating effect that this event can have on a woman suffering recurrence, even if you reassure her that it may not have any adverse impact on survival.

The current debate for and against RAND is reminiscent of the debates in the surgical and oncology literature of the 1970s concerning staging laparotomy for Hodgkin's disease. With improving non-surgical staging techniques (such as CT scanning of the abdomen) and increasing efficacy of systemic therapies, the need for staging laparotomy was lost. Hopefully the same will happen for axillary surgery in breast cancer. However, we do not yet have a staging investigation which will accurately predict the negative axilla. We do not yet have systemic therapy which will consistently control local disease. Until we have developed these improvements, I will stick with Ian Fentiman's view that RAND should remain part of the primary management of breast cancer (my non-surgical colleagues agree!).

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