associated with benign breast disease. Morphologically, a central area of lucency in a calcium deposit is virtually always associated with benign processes. Certain patterns, however should arouse concern, for example, extensive comedocarcinoma is associated with large areas of mammographically visible calcium deposits. Their mammographic pattern was characterized by a strikingly wild, chaotic appearance with profuse deposition of calcium. Many deposits may have typically benign morphology. Shape of microcalcifications is again important in such cases. The radiological suspicion should be raised, when these calcifications are interspersed with more irregular appearances resulting in overall heterogeneity. When such patterns occur, diffuse breast cancer should be suspected and follow up or biopsy of that area should be considered.

In this study, 21 out of 68 patients with microcalcifications were histopathologically proven to have breast cancer hence, biopsy yield in Radiology department at AKUH is 30.88%. According to Lawrence Bassett12, 27% of biopsies yield malignancy at pathological evaluation. In another article, Edward Sickles13 has stated that biopsies carried out for indeterminate calcifications, about 20-30% cases are proved to be cancer, and this percentage for positive biopsy result is given in several studies. Experts opinion on the necessity for biopsy about suspicious microcalcifications in the Radiology Department at AKUH yielded 45.71% results positive for malignancy while in another study it is about 34.6%.

References


Points of View

Anatomy of the Living

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Anatomy is the science of bodily structure. Historically the physicians learn the internal anatomy of the humans by dissecting the dead. With the advent of the microscope the naked observations were extended to the tissue and cellular levels. The development of electron microscopy fifty years back provided details at the subcellular level. The major limitation of the two techniques was that they were only possible after the death of the individual or after removing tissue from the living body.

The study of structure during life was only possible during surgery and with advances in surgery this has gained importance in our understanding of the structure of the human body. About hundred years back the discovery of X-rays opened up another dimension for studying the structure of the living human body.

The last few years have seen major advances in our ability to study the internal anatomy of the living person. These include Computerised Axial Tomography (CAT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), various modalities of Ultrasound, Angiography and other dye injection techniques and radioisotope scans. Endoscopy, or direct visual examination with the help of fibre-optics has added another dimension to the study of structure of a living person.

These techniques now allow us to study 'functional anatomy' which is much more relevant to daily clinical practice. Unfortunately, these modalities of studying the anatomy of the living are neglected in the undergraduate Anatomy courses.

Parallel developments in technology have now made
it possible to prepare realistic models which can be dismantled and reassembled. Similarly CDs showing different aspects of gross and histology are supplementing the traditional methods of the study of human anatomy. All these developments have now made it possible for undergraduate students majority of whom are going to become Family Physicians to learn human anatomy without the need of dissecting the dead body.

After these developments I feel the time has come when the dissection of human body as a requirement of undergraduate teaching should be given up. The moral justification for dissecting a dead body at least for the undergraduate is not there any more. There is some justification for doing so for postgraduates training for surgical disciplines.

The undergraduate anatomy should concentrate on the anatomy of the living and utilize teaching aids like models and CDs as a substitute for dissection.

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**Case Reports**

**Baso-Squamous Cell Carcinoma - a Case Report**

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**Introduction**

Basosquamous cell carcinoma (BSCC) is a rare variant of basal cell carcinoma, which carries poor prognosis because of its metastatic potential. We present a case of BSCC of face, treated with radical surgical and adjuvant radiation. This case report stresses the need to critically differentiate BSCC from the close terminology of Basaloid squamous cell carcinoma which is an aggressive variant of squamous cell carcinoma occurring in the upper aerodigestive tract.

**Case Report**

A 65 year old male reported to Ear, Nose and Throat (ENT) outpatient with painful ulcerative lesion of left lower two third of face. It started as a tiny lesion at left nasomaxillary groove one year back. This gradually increased in size. On clinical examination, it was an ulcerated lesion of 5 cm x 3 cm involving whole upper lip and left angle of mouth but sparing right angle mouth. The lesion extended to involve lower half of columella and adjacent zygomatic area. The margins were irregular and the base was covered with purulent odouriferous secretion with numerous maggots crawling in it. Plain x-ray paranasal sinus (Water's view) did not depict any bony erosion.

Presumptive diagnosis of basal cell carcinoma was made. After cleaning, debridement and parental antibiotics, the whole lesion was excised. On histopathological examination it was diagnosed as Baso-squamous cell carcinoma. The specimen revealed ulcerated surface squamous epithelium. Intact skin adnexa were however present. At low power, the tumor cells were predominantly arranged as cords (Figure 1). There were two types of cells. The peripheral cells were small and arranged in a palisading pattern. Centrally, the cells showed squamoid differentiation with keratin formation, which were more obvious at high power (Figure 2). Brisk mitotic activity was...