Tru-cut biopsy as the initial method of tissue diagnosis in bone tumors with soft tissue extension

Sir,

I read with great interest the article by Joshi *et al.* titled "Tru-cut biopsy as the initial method of tissue diagnosis is bone tumors with soft tissue extension."[1] The authors have stressed that a Tru-cut biopsy can be carried out with ease without much training, at peripheral nonspecialized centers and have a high yield and accuracy. The study is appreciable, but I want to highlight a few points.

It is unclear from the manuscript whether the local imaging magnetic resonance imaging (MRI) was performed before the biopsy for all patients, if yes then MRI (the modality of choice for local evaluation) can easily guide a surgeon/clinician to target the area of high yield and palpatory method may not be of much relevance.[2]

The article states that biopsies can be carried out by "untrained" residents or clinicians who are aware of the principles of musculoskeletal biopsy. It definitely sounds practical, especially in developing countries where many specialized sarcoma treatment centers are not available. However, it must be guided or done in consultation with the treating surgeon who will be doing the final surgery. Young clinicians and residents may not be experienced enough to decide the final plan of surgery in all cases and errors are more likely.[3]

The authors have also compared their study with published studies, which have used various imaging modalities for guided biopsy. This may not be appropriate, since the clinical spectrum of cases is strikingly different. In the present study, all cases have a large extraosseous soft tissue component while most of the western studies are on patients who have small tumors without palpable lesions and thus may require image guidance. Hence, the two groups are not comparable.

Although the numbers are small, the study stresses the need to train more and more general orthopedic surgeons and residents, in doing basic evaluation procedures like Tru-cut or open biopsies in an oncologically appropriate way. This is very essential in developing countries where a considerable mismatch exists between the ratio of specialized sarcoma centers and the catering population. Tru-cut biopsy is less invasive, less morbid and cost effective, has a shorter learning curve and appear more forgiving as compared to open biopsy. This however, requires an expert pathologist and seamless clinical, radiological and pathological correlation to have a high yield of accurate diagnosis. It can also be concluded that the extraosseous soft tissue component of a bone tumor is easily biopsiable and has comparable yield with bone biopsy if appropriate areas are selected by prior local imaging.

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