

An urgent need to reduce re-operation rates after breast conserving surgery

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The paper by Jeevan and co-workers about reoperation rates after breast conserving surgery (BCS) in England is an important and crude picture of reality. The paper describes the common practise among English NHS trust on the management of women undergoing BCS for breast cancer. The outcomes and conclusions may have a considerable impact on our patients and this type of robust national data analysis should be carried out in every country and published to see how breast cancer is treated.

The first point to consider is the audit showed that 42.3% underwent a mastectomy as primary surgery thus reflecting an aggressive surgical approach despite BCS having the same overall survival outcome (1,2).

The second point of note is that 20% of patients underwent further surgery following BCS. Moreover, reoperation was nearly twice as likely when the tumour had an *in situ* component coded (29.5% *vs.* 18%), and about 40% of the patients requiring reoperation had a mastectomy (7% of all patients).

A 20% re-operative rate is not an acceptable figure. Not only does it cause patient dissatisfaction from a cosmetic point of view but must also affect them psychologically. Re-operative surgery also has a huge financial impact especially in the present economical environment. Furthermore, it is not clear whether the subsequent delay in adjuvant treatments is detrimental to patients but for sure it does not represent an advantage.

In the EUSOMA statement on quality indicators of breast cancer care (3) it was considered 80% as minimum standard and 90% as the target the proportion of patients with invasive cancer who received a single breast operation for the primary tumour (excluding reconstruction), without though separating between patients receiving breast

conservation or mastectomy as primary surgery.

Physicians dealing with breast cancer patients should carefully rethink their management strategies in order to try and reduce their reoperation rates targeting to be between 5-10%.

In theory this objective can be easily achieved. Firstly, thorough pre-operative assessment along with a precise localization of impalpable lesions is crucial to reduce reoperation rates (4). Secondly, we should acknowledge that the evaluation of margins is basically a random biopsy of the specimen. Therefore surgeons should realize that further re-excision of the margins is similar to another random biopsy and it becomes more difficult if the breast tissue was remodelled in the original operation. Do we really believe that a re-excision procedure is going to detect cells left behind in the previous operation? Do we really believe that the surgeon will be able to identify the exact accurate position of the original cancer within a seroma filled cavity?

Finally, our feeling is that conservative surgery to achieve better cosmetic results is sometimes too limited leading to an unacceptable rate of re-operative procedures. Probably we should try to perform a surgical procedure which is a reasonable compromise between the "old" quadrantectomy which involved removing a very large amount of tissue and a limited lumpectomy which would result better cosmetic appearance but poor excision margins.

At the European Institute of Oncology of Milan we do not have an obsessive attitude towards surgical margins after BCS. Re-excision of both close margins or even in the presence of focal positive margins for both *in-situ* or invasive cancer is not generally recommended. The attempt is to have a grossly 1 cm free margin and all cases are assessed by macroscopic pathological evaluation while the patients

are still in the operating theatre. In our experience of 2,784 patients who received BCS+ whole breast radiotherapy between 2000 and 2003 the 5-year cumulative incidence of local recurrence was 1.1% (5) suggesting that in 21st century outcome of BCS is dramatically better than in the past due to a general improvement of patient management, both from the diagnostic and the therapeutic point of view. These findings along with the substantial differences found in the adjusted reoperation rates among the NHS trusts, should lead us to treat breast cancer patients in specialised centres where a minimum number of cases are performed per year but also where there is availability of on-site radiologist and pathologist. This will translate for better surgical results as well as in a better survival outcome which is the most important factor for breast cancer patients. Which in the end is what matters.

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