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Improving Results in Oncoplastic Surgery

I agree with Dr. Losken and Dr. Chatterjee about oncoplastic surgery. The authors state, “It is important to minimize complications through appropriate patient selection and technical considerations and to manage the patient as part of a team.”¹ However, I believe that evidence-based surgery is necessary to improve results in oncoplastic surgery, combining the best research evidence, patient values, and surgical experience (Fig. 1).

As regards research evidence, oncoplastic surgery is considered a safe and effective option for treatment of breast cancer, as proven by clinical trials²; it permits improvement of aesthetic outcomes while increasing the chances of no involved surgical margins. Indications and techniques vary, and some algorithms have been designed to ease decision-making.^{1,3} Technical choice depends on breast characteristics (size, shape, and glandular density), size and location of tumor, extent of resection, comorbidity, and previous surgery.^{1,3}

As regards patient values, women should be managed not only with research evidence but also with a treatment adapted to their specific characteristics, personal preferences, and attitudes toward disease. A conscientious surgeon should always involve the patient in decision-making and guide her through the different options⁴; the patient should be informed about the benefits of but also the possible problems with oncoplastic surgery to obtain a proper and conscious informed consent. Concerns, such as longer operative times, increased risk of complications with sequelae on

quality of life, and possible delay in adjuvant therapy, should be considered. The patient should be apprised of the possibility of positive margins and the potential need for secondary surgery. Proper clinical counseling and appropriate psychological support should be offered within a multidisciplinary path.

As regards surgical expertise, oncoplastic surgery includes a set of complex procedures that require adequate learning, specific training, and surgical dexterity; however, individual ability alone is not enough to obtain a successful result. A modern surgeon must have technical capacity but also perform specific tasks within a standardized pathway, as follows⁵:

- Proper preoperative study with mammography ultrasonography and selective use of magnetic resonance to assess the extent of disease, estimate the percentage of tissue to be resected, and localize the tumor.
- Dedicated “surgery board,” with a multidisciplinary discussion to evaluate candidates for oncoplastic surgery and select the best technique tailored to the patient; an assessment of the likely cosmetic outcome of lumpectomy should be performed before surgery.
- Use of intraoperative ultrasound to perform a precise resection while sparing healthy tissue.
- Careful dissection by electrocautery, with preservation of appropriate subcutaneous thickness to spare vascularity and reduce the risk of nipple-areola and skin ischemia.
- Intraoperative radiological and pathological evaluation of excised tissue to define margins of resection; frozen sections should be performed from each face of the specimen.
- Circumferential cavity shaving to increase the chances of negative margins.
- Careful palpation and ultrasound of residual gland to verify the absence of further tumor foci.
- Placement of clips within the tumor cavity as markers to guide adjuvant radiotherapy.
- Careful histopathological evaluation using macrosections.

I firmly believe that evidence-based surgery and the performance of these specific tasks are mandatory to obtain a successful oncoplastic surgery and make the patient co-responsible for the results within a multidisciplinary pathway.

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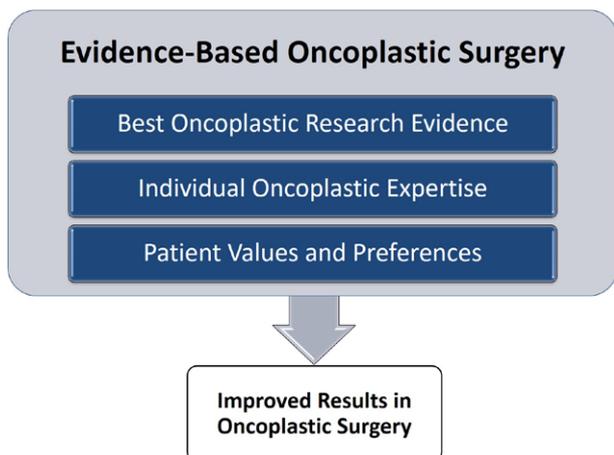


Fig. 1. Components of evidence-based oncoplastic surgery to improve patient outcomes within a multidisciplinary pathway.

DISCLOSURE

The author has no financial disclosure or conflicts of interest to report.

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Reply: Improving Results in Oncoplastic Surgery

We would like to thank Dr. Franceschini for his thoughtful letter regarding the importance of evidence when it comes to the field of oncoplastic surgery and for his comments on our recent article, “Improving Results in Oncoplastic Surgery.”¹ When looking to improve outcomes or minimize complications in any surgical field, we all need to take a critical look at the evidence and learn from what has been studied in the past and from others’ experiences.

Evidenced-based surgery is something that we all strive to practice, as it separates us from mediocrity and provides our patients with the best opportunity for good outcomes. This is a part of the bigger concept of evidence-based practice, where the practice of any occupation should be based on scientific evidence. As with any relatively new area of focus in surgery, the initial evidence is based mainly on anecdotal reports and case series and introduction of the concept. With time and experience, discussions evolve into the indications and technical options as the approach gains acceptance and intrigue. The oncoplastic approach is no different. Since its inception in Europe, it has gained traction all over the world and is morphing into a multidisciplinary approach with the help of such evidence.

The progression that followed with the oncoplastic evidence is that reports started looking into comparisons with breast conservation therapy alone or into comparisons with mastectomy and reconstruction, with the purpose of determining the safety of this approach from an oncological perspective and then also from a general complication perspective. This spoke to the importance of understanding margin control, complication reduction (so as not to impact adjuvant therapy), and ultimately the impact oncoplastic surgery has on tumor recurrence. These are all essential topics

to discuss and study before an approach can feasibly be considered the standard of care, and the evidence-based approach is the perfect vehicle to get us there.

As Dr. Franceschini so accurately points out, the importance of patient-reported outcomes becomes equally impactful in how it takes the patient’s opinion into perspective and allows the patient to become a part of the decision-making process. This is only the case if we as surgeons use these patient-reported outcomes and adapt what we do based on them, once again highlighting the importance of using the available evidence to refine what we do to ultimately improve the patient’s outcome. Then, as the oncoplastic approach also demonstrates, the progression of a standardized definition and classification,² with the development of standardize pathways under the guidance of multidisciplinary teams, will further enhance the impact this field has on improving outcomes and access to care for women with breast cancer who wish to preserve their breasts.

We would like to thank Dr. Franceschini for his thoughts and for keeping the oncoplastic discussion alive. This is what contributes to the evolution of a concept into an accepted approach that benefits all involved.

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The Effect of Age on Fat Distribution in the Neck Using Volumetric Computed Tomography

I read with great interest Orta et al.’s article, “The Effect of Age on Fat Distribution in the Neck Using Volumetric Computed Tomography.”¹ Neck fat