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ASO AUTHOR REFLECTIONS

ASO Author Reflections: Routine Radiologic Staging of Distant Metastases Must Be Recommended as a Binding Guideline After Diagnosis of Local Breast Cancer Recurrence

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PAST

The motivation for this study[1] arose from a particular experience at the authors' Breast Center network during the last year. In two cases of local recurrence (LR), the interdisciplinary tumor board recommended staging of distant metastases (DMs) followed by a surgical intervention (after the DMs were excluded). However, the surgeons responsible for the cases first performed the operation (mastectomy) and postponed staging of the DMs to the postoperative period. In both cases, however, DMs were found. Retrospectively, it must be questioned whether these mastectomies were justified. Strictly speaking, the preoperative informed consent was invalid because patient and doctor assumed a curative approach, which was not indicated. Both doctors responsible for this management were experienced breast surgeons. Why did they omit radiologic staging procedures before surgery? Obviously, they underestimated the actual risk of DMs, which is understandable because most of the international breast cancer guidelines omit the management of LR. The few guidelines that included recommendations regarding LR and advocated radiologic staging of DM once LR is diagnosed do not substantiate their opinion with citable references from the literature.[2,3] Why? Some publications report data regarding a synchronous diagnosis of LR and DM, but this is not the main topic of these publications. Moreover, it is difficult and time-consuming to find the few relevant publications (PubMed lists nearly 3000 entries for the search for "breast cancer" and "local recurrence"). Until recently, no publications addressed this question explicitly but focused instead on the frequency of a concurrent diagnosis of LR and DM. Neuman et al.[4] were the first to address the question. Their analysis, however, was restricted to patients with advanced stages of cancer at the initial diagnosis. The current study analyzed the metastatic patterns of patients with LR in an unselected cohort that included different types of previous surgery and all non-metastatic stages of cancer at diagnosis (n = 137).

PRESENT

The authors demonstrated that in approximately 20–50% of patients with confirmed LR (dependent on LR site, stage at diagnosis, and tumor characteristics), DMs also were present.

FUTURE

This study aimed to assess whether the synchronous diagnosis of LR and DM is so high that routine radiologic staging for DM must be recommended as a binding guideline. Our data clearly justify this. All international guidelines recommend staging of DM for patients with a diagnosis of advanced breast cancer. The incidence of metastatic disease at the time of breast cancer diagnosis, even among patients with the highest non-metastatic disease stage (3C), is approximately 14%.[5] Thus, it is only logical that radiologic staging procedures must also be

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recommended for a cohort, even in a low-risk subgroup, that has a considerably higher detection rate. Confirmation of DM is essential to the planning of further therapy. This may spare the patients radical surgical interventions (especially mastectomies) that have a questionable impact on survival in the face of an incurable disease.

DISCLOSURE There are no conflicts of interest.

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