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LETTER – BREAST ONCOLOGY

Author's Response to Reflexion on Consensus Statement on Oncoplastic Surgery, by Zucca-Matthes, Gustavo, et al.

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Dear Editor,

Upon reading the letter written by Drs. Zucca-Matthes and Lebovic, we were encouraged by their response to the American Society of Breast Surgeons (ASBrS) consensus statement on oncoplastic surgery. The goal of the ASBrS consensus definition and classification of oncoplastic surgery was to create less confusion among the varying, often contradictory, definitions of oncoplastic surgery in the global arena.[1] With this, the ASBrS aims to improve its ability to educate surgeons, trainees, and patients about oncoplastic surgery and in doing so contribute to the positive spread of oncoplastic surgery nationally and globally. In giving credit, as mentioned by Drs. Zucca-Matthes and Lebovic, to past pioneers of oncoplastic surgery and also acknowledging Professor Werner Audretsch's intent with his first description of oncoplastic surgery, the ASBrS definition notes that oncoplastic surgery is a form of breast conservation that transcends the traditional partial mastectomy intent.[2] Rather than the routine surgical resection and incisional closure when removing the tumor, this form of breast conservation supplements the cancer resection with volume displacement or volume replacement reconstructive designs and a contralateral symmetry operation when appropriate.[1] In doing so, oncoplastic surgery not only improves the aesthetic outcomes but also takes full advantage of the oncologic benefits, such as lower positive margin rates in breast conservation, and the reconstructive benefits of pain relief in those breast cancer patients with symptomatic macromastia receiving Level 2 volume displacement surgery using reduction mammoplasty techniques.[3–5] Just as important, the appropriate breast cancer patient has more choices in breast conservation, and with greater adoption of oncoplastic surgery may come a reduced rate of mastectomy operations.[6] As such, the ASBrS oncoplastic surgery definition and classification system, rather than "superseding" past classifications, clarifies and prioritizes the oncoplastic principles brought forward by leaders, such as Krishna Clough and Mel Silverstein.[7,8]

The ASBrS formed its oncoplastic surgery committee with members of both breast surgical oncology and plastic surgery backgrounds, and with surgeons who practice from both community and academic settings. This was specifically done so future educational oncoplastic surgery endeavors would favor the needs of surgeons coming from varying backgrounds and expertise. It also ensures that oncoplastic surgery is taught in a safe and systematic way and the breast patient has optimal oncologic and reconstructive outcomes. While a recent ASBrS survey found massive interest in oncoplastic surgery among its membership, there was confusion on what oncoplastic surgery meant, which served as the central reason for our consensus definition.[9] Furthermore, while oncoplastic surgery rates are increasing, they still lag substantially behind other breast surgery options with mastectomy rates being approximately 50% of breast cancer surgeries performed, which many consider too high.[10,11] Having the ASBrS oncoplastic surgery definition hopefully supplements the present surge in interest for oncoplastic surgery by providing clarity and direction in what needs to be taught.

Presently in the United States, oncoplastic surgery stands at a crossroad. Past turf battles highlighted by viewpoint articles written by prominent plastic surgery leaders, such as Dr. Maurice Nahabedian sometimes overshadowed remarkably strong accomplishments by oncoplastic surgeons, such as Dr. Grant Carlson.[12,13] Fortunately, present-day leaders in oncoplastic surgery in the

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ASBrS (Dr. Juliann Reiland) and the American Society of Plastic Surgeons (Dr. Andrea Pusic) have a "patient comes first" outlook, which appears promising for future interdisciplinary collaboration in breast surgical education. Thus, the increasing interest by both breast surgeons and plastic surgeons in oncoplastic surgery serves to benefit the breast cancer patient for reasons mentioned above. While a two-surgeon model has persisted traditionally in the United States, single-surgeon models, highlighted by the Europeans and South Americans, have been shown to be safe and beneficial especially in the realm of oncoplastic surgery.[14–16] As surgeons and members of surgical societies, interdisciplinary collaboration in creating educational programs that teach oncoplastic techniques should be encouraged so patients have access to these breast conservation options in a safe manner. Specialty turf and misguided loyalty should never supersede our obligation to the breast cancer patient, which includes providing reasonable and safe access to appropriate breast surgical options. This was true when Professor Werner Audretsch published his first oncoplastic surgery description in 1998, and it should hold true even today.[2]

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