



GUIDELINES

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Letters

Oncoplastic Surgeons: Heros or Villains?

Sir:

As a U.S. breast surgeon completing an international oncoplastic fellowship, and a Brazilian oncoplastic breast surgeon and medical school professor of bioethics who has mentored tens of other international breast surgeons, we read with great interest Dr. Nahabedian's Editorial.¹ After analyzing his opinions about the boundaries between plastic surgery and breast surgery, we wanted to take a closer look not only at the evolving field of oncoplastic surgery, but also at medical professionalism and mission.

The welfare of the patient should always be of paramount importance in our medical practice.

Unfortunately, the breast cancer patient, regardless of which country you are from, hospital system you work in, insurances you accept, or the socioeconomic status of the patient, is not being adequately cared for in terms of breast reconstruction. In the United States, although the rates of postmastectomy breast reconstruction are better, and have improved recently, they are not homogeneous, and most patients do not undergo immediate breast reconstruction.²

The "oncoplastic movement," as Dr. Nahabedian has called it, is not limited to Europe but is a worldwide movement. We believe there are three main factors explaining the rapid growth of this movement. The first is the extraordinary success in breast cancer treatment, a real triumph of evidence-based medicine. Early diagnosis and improved medical therapies have improved cure rates and disease-free survival, which has resulted in increasing indications for breast reconstruction. Consequently, we need an increased supply of sophisticated full-time reconstructive surgeons, regardless of their background in plastic or oncologic surgery, who can integrate all of these advances and make the most informed surgical decisions.

In light of all these advances and the increased need for reconstructive surgeons, discussions about boundaries in ablative or reconstructive surgery or, worse yet, on who should be trained in a surgical field to preserve the identity of our specialties seem unreasonable. It is clear to all of us that unqualified surgeons should not perform this surgery, to maintain the safety of our patients, but not the integrity of specialties. We would all agree that increasing the supply of well-qualified reconstructive surgeons in the United States, regardless of their background, would serve to increase the rate of immediate reconstructions performed today.

We believe that Dr. Nahabedian's remarks that breast surgeons could become skilled in implant-based and pedicled flap reconstructions if trained properly but that plastic surgeons should avoid this in the interest of protecting their specialty are counterproductive. The free exchange of ideas and knowledge between competent physicians only serves to better the standard of care for our patients and makes for a more stimulating and vibrant specialty. In the same way, we also disagree with his criticisms of plastic surgery graduates seeking additional training or experience in surgical oncology. In fact, many plastic surgeons today have completed general surgery residencies and are fully qualified to perform oncologic surgery. We would encourage interested plastic surgeons to seek additional training in oncology and to become oncoplastic surgeons. There are many successful examples of cross-over skills between specialties in which the specialty and patient safety are not compromised.

The second point relates to patient expectations with the aesthetic outcome after breast cancer surgery. Although there are many social and cultural differences between patients, women in general love their breasts. They want to maintain their body integrity

and their feminine identity, avoiding the unnecessary mutilation of cancer surgery without reconstruction. The vast majority of breast cancer patients, if given the opportunity, would want to undergo reconstruction of their breasts during the same operation, and should have the right to do so. We should respect their autonomy and dignity. Who is the best person to provide this service to the patient: a breast surgeon or a plastic surgeon performing breast reconstruction? There are no data to answer this question. Breast reconstruction should be a common field between specialties; thus, the real question here is not who should do it, but how should it be done in the best and safest way. How should surgeons be trained in breast reconstruction in a time when breast cancer treatment has become one of the most complex and dynamic in all of medicine? Here, rigid boundaries will not help our patients.

We would also argue that the majority of breast surgery performed today is breast-conserving surgery performed by oncologic surgeons without the help of plastic surgeons. Increasing the skills of these surgeons in aesthetic principles would only improve the quality of aesthetic outcomes for these patients. We understand the fear on the part of plastic surgeons that allowing breast surgeons to perform reconstructive surgery might result in decreased referrals for breast reconstruction. We feel this concern is misguided. The vast majority of women in the United States do not have access to immediate breast reconstruction for a variety of reasons, including availability of qualified surgeons and poor education by their ablative surgeon. Increasing the pool of qualified surgeons will only increase the awareness on the part of patients and referring physicians, who will demand this care, resulting in more than enough referrals for all surgeons, regardless of their specialty.

We also feel that oncoplastic surgery will not necessarily end the relationship between plastic and breast surgeons. Many of these operations are long and difficult procedures, requiring careful attention to detail. Would it not be in the best interest of the patient to have two skilled surgeons performing her surgery with interchangeable skills, with perhaps one surgeon being more of the aesthetics expert and the other being more of the oncologic expert? This would most likely result in a quicker and better performed operation.

The third contributing factor is medical professionalism. By this, we are referring to the social contract between doctors and society, and the way in which we fulfill our obligations of this contract. We believe that the great majority of surgeons who are learning new skills are doing so not in their own self-interest but, instead, because of their commitment to the patient, who otherwise is not receiving the best treatment. Dr. Nahabedian acknowledges that the field of reconstructive breast surgery is “somewhat fragile because of its relatively small constituency.” We agree with him that the interest on the

part of plastic surgeons is waning as evidenced by poor attendance at national meetings, workshops, and formal surveys. In contrast, the interest on the part of breast surgeons in this new field is exploding. Why not welcome this new influx of motivated and talented individuals to enrich a “fragile specialty” and help take care of the many breast cancer patients who go without reconstruction?

The final and perhaps greatest concern with this Editorial is related to the author’s conclusions. He submits that plastic surgeons should deter this “movement,” as it is in the self-interest of the specialty. Plastic surgeons and breast surgeons are not at war. The goal of this movement is not to replace plastic surgeons in breast reconstruction.³ There are many breast surgeons and plastic surgeons that work together very well and will continue to do so even if we are now crossing the gap between specialties. Contrary to what this movement seems to mean to some surgeons, the aim here is for breast and plastic surgeons to work together to share skills and experiences and to improve the accessibility of breast reconstruction to as many women as possible. In the end, we believe this should not be about “protecting our specialty”; instead, as we all promised in our Hippocratic Oath, it is about protecting our patients, our real mission.

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DISCLOSURE

The authors have no financial interest to declare in relation to the content of this communication.

REFERENCES

1. Nahabedian MY. “Plastic surgery”... beware. *Plast Reconstr Surg*. 2014;133:965–966.
2. Jagsi R, Jiang J, Momoh AO, et al. Trends and variation in the use of breast reconstruction in patients with breast cancer undergoing mastectomy in the United States. *J Clin Oncol*. 2014;32:919–930.
3. Urban CA. Oncoplastic in a pre-paradigm era: A Brazilian perspective in an American problem. *Plast Reconstr Surg*. 2010;125:1839–1841; author reply 1841.