CORRESPONDENCE

Breast Cancer Morbidity: Questionnaire Survey of Patients on the Long Term Effects of Disease and Adjuvant Therapy

by Stefan Feiten, Dr. med. Jan Dünnebacke, Dr. med. Jochen Heymanns, Prof. Dr. med. Hubert Köppler, Dr. med. Jörg Thomalla, Dr. med. Christoph van Roye, Diana Wey, Prof. Dr. med. Rudolf Weide
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Positive Psychological Effects

Recording and evaluating morbidity after combined breast cancer therapy using surgery, chemotherapy, and radiotherapy is crucial and important in order to develop an adequate and differentiated treatment strategy for affected women. Mastectomy alone without breast reconstruction has—as was shown in the study and is widely known from the literature—a negative physical (dysbalances) and primarily psychological effect on patients. On the basis of our clinical practice, however, we think that the authors' recommendation to use breast conserving surgery whenever it can be medically justified actually falls short. Techniques of breast reconstruction by using implants in patients who have not had radiotherapy and by free microsurgical tissue transfer allows a reconstruction of "femininity," with corresponding positive psychological effect. In our opinion, of the total cohort of patients in the study, the subgroup of patients who had breast reconstructions should be analyzed separately and added accordingly.

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Different Procedures Should Be on Offer

Mastectomy undoubtedly constitutes a substantial obstacle to satisfaction and quality of life. The authors showed clearly that patients were explicitly more satisfied with their outcome after breast conserving treatment than patients who had had mastectomies. This is not surprising as the discrepancy in the aesthetic result is obviously high. Of greater interest, however,

would have been a comparison between patients after breast conserving therapy and patients after mastectomy with subsequent breast reconstruction. The authors did not comment in the present article whether breast reconstruction had any effect on patients' satisfaction.

According to the current S3 guideline, every patient who had to undergo a mastectomy should be informed about and offered a choice of different procedures for reconstruction of the breast. Implant based reconstruction as well as breast reconstruction using the patient's own tissue (flap reconstruction) are possible in certified breast centers using interdisciplinary approaches, owing to the increasing standardization of surgical techniques with high success rates. Breast reconstruction is therefore an elementary component of modern breast cancer therapy, and the impressive positive effect on the quality of life in affected women has been confirmed several times (1–3).

In our view, the statement that "breast-conserving surgery should be preferred whenever it can be medically justified" needs to be further qualified. Although breast-conserving treatment should be the aspired objective, mastectomy with subsequent breast reconstruction can yield aesthetically more pleasing results in the individual case scenario. Competent interdisciplinary advice and careful planning of therapy and surgery are the crucial prerequisites of an optimal oncological and aesthetic outcome.

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In Reply:

Both commentaries, by Penna et al. and Hernekamp et al., ask the justified question of whether breast reconstruction after mastectomy affects patients' subjective satisfaction with the surgical outcome. One may assume—and the literature cited by Hernekamp et al. would support this—that patients are more satisfied with the cosmetic result after successful breast reconstruction than patients without reconstruction.

In our article, patients' subjective assessments of the surgical outcome relate to the time of their initial breast cancer treatment. The routine data available to us do not allow for any further analyses. All we were able to establish was whether initially a mastectomy had been done or whether patients had had breast conserving surgery. We do not have any information on the subsequently provided reconstructive therapy, whether implant based or as flap reconstruction. For this reason we cannot comment on the different aspects of surgical breast reconstruction after mastectomy.

What we showed is from the patients' perspective a notably higher degree of satisfaction with the surgical treatment outcome after breast conserving therapy. Similarly, significantly fewer complaints relating to arm swelling and impaired shoulder/arm function were observed after breast conserving therapy. These descriptions from patients' perspectives are confirmed by the literature (1, 2). With regard to the adverse effects of surgical therapy, not only the method of breast surgery should be mentioned but also the axilla. Patients who had not had an axillar dissection complained significantly less often about ipsilateral arm swelling and impaired shoulder and arm function. This is also confirmed by the literature (3, 4).

We therefore wish to underline our statement that, whenever it is medically justifiable, breast conserving surgery should be the method of choice. Furthermore, also whenever it is medically justifiable, the axilla should be operated as non-radically as possible. The

question raised by Penna et al. and Hernekamp et al., which is so very important in our opinion too—of the extent of which reconstructive breast surgery has a positive effect on breast cancer patients' shoulder/arm function, arm swelling, esthetic self image, and psychosocial wellbeing—should be the subject of a separate prospective study. We wholeheartedly agree that only competent interdisciplinary advice/information, therapy planning, surgery, and systemic therapy will yield an optimal oncological and esthetic result.
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