EDITORIAL

Treatment Quality in Breast Cancer

Numbers, Age, and Breast Reconstruction

Carolin Nestle-Krämling, Christoph Andree

An editorial to accompany the articles:

„The treatment of primary breast cancer in older women with adjuvant therapy“ by Elke Peters et al.

„Case numbers and process quality in breast surgery in Germany“ by Christina Köster et al. and

„Breast reconstruction following cancer treatment“ by Bernd Gerber et al.,

in this issue of *Deutsches Ärzteblatt International*

The focus of this edition is provided by three articles on breast cancer. The care situation for older women receiving adjuvant therapy for breast cancer is represented by findings from the PATH tumor database based on patient reports on initial diagnosis and after two years' follow-up (1). Research by the AQUA Institute analyzes the relationship between case numbers and quality of care for breast surgery in Germany (2), while a recent review article sorts the extensive data on breast reconstruction following breast cancer (3).

Prevalence

In Germany, breast cancer is the most common tumor disease in women, with more than 70 000 new cases per year (4). More and more women in older age groups will be affected in the future. As the development of certified breast centers has been ongoing for more than 12 years, high-quality, guideline-compliant systemic and oncological/reconstructive surgical care should now be available for all or at least for a majority of breast cancer patients. Surprisingly, only around 20% of all women in Germany currently receive or want breast reconstruction following mastectomy; this has been shown by an evaluation of data from the West German Breast Centre (WBC, Westdeutsches Brustzentrum) by Meyer-Marcotty et al. (5). There were differences in breast reconstruction rates in line with age, ranging from only 6% in those aged over 60 years to 20% in those aged between 40 and 60 years. Thus, age plays a role. Wishes and health may differ objectively according to age, but the possibility that physicians may provide different counseling, explanations, and treatment options to patients of different ages cannot be ruled out.

Less common as age increases

The article on adjuvant therapy discusses the fact that older women aged over 69 years, who accounted for 22% of the more than 3200 women in the study, were less likely to receive breast-conserving therapy, appropriate adjuvant systemic therapy (chemotherapy, anti-hormone therapy, or antibody therapy), or adjuvant radiotherapy than younger women (1). Later tumor stages and more unfavorable tumor biology were also significantly more common in the oldest patients. These statements confirm the findings of other research (6–8). In fact, in the last 15 years the breast cancer-specific mortality rate in women aged over 69 years in

Germany has fallen less than the rate in younger women (4). There are various possible reasons for this, such as younger patients' better access to participation in studies with innovative treatments or better treatment compliance as a result of better health. Alternatively, might this perhaps be evidence of an inappropriate failure to offer older women more intensive but guideline-compliant treatments? This research cannot provide a definitive explanation but certainly can increase awareness of guideline-compliant, age-appropriate treatment planning.

Higher case numbers correlated with positive quality parameters

Further insight and a finishing note to the studies on quality of surgical care for breast cancer are provided by the analysis of data from external inpatient quality assurance performed by authors at the AQUA Institute on structural processes in hospitals of various sizes (2). The analysis shows that higher case numbers also correlated with positive quality parameters. This finding is interpreted as showing that guidelines are obviously better implemented in hospitals with higher case numbers. The positive correlation between guideline compliance and oncological outcome is well-known (9). The validity of the urgent recommendation for women with breast cancer to be diagnosed and treated only in certified breast centers is confirmed in this analysis, although outcome parameters would enable much more definite statements to be made than process parameters. However, if a cut-off point can be inferred from the case number groups in the data presented here, interestingly, it would be a case number of 50 per year, substantially lower than the minimum number of 150 primary cases per year required of breast centers. Centers that treated more than 100 or more than 150 cases were no better than those that treated between 50 and 100 cases. In contrast, one parameter—frequency of longer waiting times from diagnosis to surgery, lasting more than three weeks—worsened again in centers with the highest case numbers. Reasons for this in hospitals with very high case numbers may be both capacity problems and higher use and implementation of complex diagnostics, including interface-related problems of associated screening units. However, the fact that certified centers with high use achieve better outcomes means that money should be invested in this.

Department of Senology, Sana Hospital Gerresheim, Düsseldorf:
Dr. med. Nestle-Krämling

Department of Plastic and Aesthetic Surgery, Sana Hospital Gerresheim, Düsseldorf:
Prof. Dr. med. Andree

The review article by Gerber et al. on breast reconstruction summarizes a wealth of newer publications and scientific findings (3). However, as is often the case with surgical issues, these sources do not achieve a high level of evidence, as there is a lack of randomized trials. It is therefore extremely important that the best available evidence be defined. Increasingly promising possibilities for reconstruction, with dramatically better aesthetic outcomes than in the past, must be planned in the context of sometimes highly complex oncological issues for optimal patient benefit: now or later? Before or after chemotherapy? Before or after radiotherapy? Implant, autologous tissue, or both? There is no simple procedure for such decisions, but patients should be aware of the options.

Tailored therapy

New treatment options and, of course, options for breast reconstruction should be tailored to both the individual patient's tumor stage and to her wishes and life situation. They should be offered to patients of all ages. It is important to understand that breast cancer is not an emergency and that there should be sufficient time for patients to obtain good-quality, comprehensive information in certified breast centers. Treating physicians must inform all patients individually of the various treatment options, particularly the types of reconstruction now available. This includes those they do not themselves perform.

Conflict of interest statement

Dr. Nestle-Krämling has received consultancy fees from Pharm Allergan and pfm. She has received fees for preparing scientific/surgical workshops from Serag Wiesner. She has received payment into a third-party account for conducting clinical trials from Pharm Allergan.

Prof. Andree declares that no conflict of interest exists.

Translated from the original German by Caroline Shimakawa-Devitt, M.A.

REFERENCES

1. Peters E, Anzeneder T, Jackisch C, et al.: The treatment of primary breast cancer in older women with adjuvant therapy—a retrospective analysis of data from over 3000 patients from the PATH Biobank, with two-year follow-up. *Dtsch Arztebl Int* 2015; 112: 577–84.
2. Köster C, Heller G, Wrede S, König T, Handstein S, Szecsenyi J: Case numbers and process quality in breast surgery in Germany—a retrospective analysis of over 150 000 patients from 2013 to 2014. *Dtsch Arztebl Int* 2015; 112: 585–92.
3. Gerber B, Marx M, Untch M, Faridi A: Breast reconstruction following cancer treatment. *Dtsch Arztebl Int* 2015; 112: 593–600.
4. Meyer-Marcotty MV, Hankiss J, Flügel M, Redeker J: Breast reconstruction for patients with breast carcinoma: an analysis based on the data of 4,335 patients from 16 hospitals. *Chirurg* 2007; 78: 637–42.
5. Kosiak B, Sangl J, Correa-de-Araujo R: Quality of health care for older women: What do we know? *Women's Health Issues* 2006; 16: 89–99.
6. Waldmann A, Pritzkeleit R, Raspe H, Katalinic A: Guideline-compatible treatment of breast cancer patients – The status quo in Schleswig-Holstein. *Dtsch Arztebl Int* 2008; 105: 337–43.
7. Ebner F, van Ewijk R, Wöckel A: Tumor biology in older breast cancer patients—what is the impact on survival stratified for guideline adherence? A retrospective multi-centre cohort study of 5378 patients. *Breast* 2015; 24: 256–62.
8. Beckmann MW, Brucker C, Hanf V: Quality assured health care in certified breast centers and improvement of the prognosis of breast cancer patients. *Onkologie* 2011; 34: 362–7.

Corresponding author:

Dr. med. Carolin Nestle-Krämling
Sana Kliniken Gerresheim
Breast Department
Gräulinger Str. 120
40625 Düsseldorf, Germany
dr.nestle-kraemling@t-online.de

Cite this as:

Nestle-Krämling C, Andree C: Treatment quality in breast cancer—numbers, age, and breast reconstruction. *Dtsch Arztebl Int* 2015; 112: 575–6.
DOI: 10.3238/arztebl.2015.0575