Delivering Breast Reconstruction Information to Patients—Part 2: Women Report on Preferred Information Content

La transmission d'information aux patientes sur la reconstruction mammaire – Partie 2 : rapport de femmes sur l'information privilégiée

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Abstract

Purpose: To determine the type of information women want to be provided in order to make an informed decision as to whether, when, and using what technique to proceed with breast reconstruction. **Method:** Using purposeful sampling, 19 patients who had recently undergone various breast reconstruction procedures were recruited to each participate in a 30- to 45-minute semi-structured interview. Participants shared their insights and beliefs regarding the type of breast reconstruction information they most valued prior to undergoing breast reconstruction surgery. Participants were also queried as to perceived information gaps. In some cases, the participants' partners or support persons were also interviewed. Grounded theory and thematic analysis assisted in interview transcript analysis. **Results:** Eight topics were identified relating to women's informational needs around breast reconstruction. Examples include how to weigh the pros and cons of various breast reconstruction options to decide between flap or implant reconstruction, whether there are safety concerns with immediate breast reconstruction or nipple-sparing reconstruction, and expectations and advice on how to manage possibly unexpected intimacy issues after breast reconstruction. **Conclusions:** Using mixed methods research methodology, 19 women reported on preoperative informational gaps relating to their recent breast reconstruction experiences. Patients report that adequate breast reconstruction information prior to breast reconstruction surgery helps them to manage their expectations, prepare for surgery and recovery, and improve postoperative satisfaction.

Résumé

Objectif : Déterminer le type d'information que les femmes veulent recevoir pour décider de manière éclairée si elles veulent subir une reconstruction mammaire, le moment de la subir et la technique à privilégier. **Méthodologie :** À l'aide de l'échantillonnage raisonné, 19 patientes qui avaient récemment subi des reconstructions mammaires différentes ont été recrutées pour participer à des entrevues semi-structurées individuelles de 30 à 45 minutes. Elles ont donné leur point de vue et leur avis quant au type d'information sur la reconstruction qu'elles trouvaient le plus important avant l'opération. Elles ont également été invitées à confier leurs perceptions à l'égard du manque d'information. Dans certains cas, les chercheurs ont également interviewé les conjoints ou les proches aidants des participantes. La théorie ancrée et l'analyse thématique ont contribué à l'analyse des entrevues après leur transcription. **Résultats :** Huit sujets ont émergé quant aux besoins d'information des femmes sur la reconstruction mammaire. Les exemples incluaient la manière de soupeser le pour et le contre pour choisir entre la reconstruction par lambeau ou par implant, les enjeux de sécurité d'une reconstruction mammaire immédiate ou d'une reconstruction avec épargne mammaire, de même que les attentes et les conseils sur la gestion du risque de problèmes d'intimité inattendus.

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après la reconstruction mammaire. **Conclusions :** À l'aide d'une méthodologie de recherche mixte, 19 femmes ont confié les insuffisances d'information dont elles avaient eu l'expérience avant leur récente expérience de reconstruction mammaire. Elles ont déclaré que la transmission d'information appropriée sur la reconstruction mammaire avant l'intervention contribue à gérer les attentes, à se préparer à l'opération et à la convalescence et à accroître la satisfaction après l'opération.

Keywords

breast cancer, breast reconstruction, decision-making, information gaps, information transfer, patient satisfaction, quality of life

Introduction

Over the past 20 years, breast reconstruction has become more widely available and easier to access, yet rates of reconstruction remain relatively low in Canada.¹ Highly trained oncology care providers do not always provide information on breast reconstruction, although breast reconstruction in patients with mastectomy has been shown to improve quality of life and have long-term psychosocial benefits.²⁻⁴ This oversight may be a result of lack of knowledge of breast reconstruction accessibility or assumptions regarding which patients may or may not be eligible for or desirous of reconstruction.⁵ It may also be a consequence of training that focused solely on disease treatment, and breast reconstruction information may not be incorporated into their scope of practice.⁶ Such an environment often leaves women facing breast surgery without the information they need to make informed decisions about whether they wish to consider breast reconstruction as part of their treatment path.

There is currently a lack of research reporting on the information that patients perceive to be of interest and value.⁶ In part 1 of our report on this study, entitled "Delivering Breast Reconstruction Information to Patients: Women Report on Preferred Information Delivery Styles and Options," women who had recently undergone breast reconstruction surgery described the optimal formats for breast reconstruction information delivery.⁶ In that article, we noted that women most valued the plastic surgeon as the primary source of information but additionally preferred information delivered via multiple sources, including online resources, peer volunteers, photographs, and nurse navigators or other health-care team members. We follow this article up with the present publication in which we detail the content of information these women most desired.

Methods

Patient Recruitment and Study Design

In order to determine the information women desire prior to undergoing breast reconstruction, as previously reported,⁶ a mixed methods study of women who had undergone breast reconstruction was undertaken. Purposeful recruitment, from a single surgeon's practice, was utilized to ensure a spectrum of participants representing different breast reconstruction procedures and recovery and adaptation trajectories. Recruitment continued until thematic saturation was reached. Participants were drawn from fluently English-speaking adult women who

had undergone breast reconstruction. In accordance with institutional guidelines, an ethics review was completed through ARECCI (A pRoject Ethics Community Consensus Initiative). Informed consent was obtained from all participants. In the spirit of qualitative research, these results represent a contextualized experience and may not be generalizable.

The participants in this study had been exposed to the study surgeon's standard presurgical education practices. Each participant underwent a minimum of two 45-minute preoperative clinical consultations with the plastic surgeon, was offered the opportunity to connect with a peer volunteer who had previously undergone breast reconstruction, was given written informational material, and was emailed a breast reconstruction information video link.

Data Gathering and Analysis

In order to develop a more insightful and comprehensive investigation into our research questions than a single approach might offer,⁷ a mixed methods research methodology was applied. Quantitative data were generated by having the study participants complete the BREAST-Q post-operative breast reconstruction modules. The quantitative results were reported in the authors' prior publication.⁶

Qualitative data were gathered through individual semi-structured interviews that lasted from 30 to 45 minutes. The interview was conducted face-to-face with a research coordinator experienced in qualitative interviewing. Questions focused on 3 primary subjects of interest: breast reconstruction information content, delivery, and sources. For content information, the interviewer asked about the information participants received or wish they had received on different aspects of the reconstruction process, including options, procedures, recovery, and long-term adjustment following surgery. For delivery of information, the interviewer asked about participants' processing style, timing, and types of content delivery. For sources of information, participants were asked about who provided them with breast reconstruction information and about how much they trusted and valued those sources.

Sixteen participants chose to interview alone, while a friend or relative accompanied 3 participants. Each participant consented to study inclusion, and each of the audio-recorded interviews (including comments from the 3 accompanying guests) was transcribed verbatim, forming the interview transcripts.

Using the interview transcripts, 2 of the researchers reviewed the data using thematic analysis to identify and organize themes.⁸ Researchers identified themes emerging from the

3 primary subjects of interest—content, sources, and delivery modalities—while also remaining open to unanticipated topics of relevance introduced by study participants.

Results

Of the potential participants who were screened and met the inclusion criteria, 19 women, aged 38 to 69 years (mean age 54 years), volunteered to participate in this study. Of the 19 participants, 17 had immediate reconstruction and 2 had delayed reconstruction. Diagnoses varied, with 10 patients diagnosed with invasive breast cancer, 7 with DCIS, and 2 with a BRCA-positive diagnosis leading them to choose prophylactic mastectomies. Twelve patients had unilateral reconstructions, while 7 had bilateral reconstruction. Fourteen patients had alloplastic reconstructions: 7 direct-to-implant using the patients' own dermal tissue as a sling, 6 two-stage expander implants, and 1 direct-to-implant with acellular dermal matrix. Three patients had a combination of alloplastic and autologous reconstructions: 2 latissimus dorsi flaps with implants and 1 thoracodorsal artery perforator flap with implant. Finally, 2 patients had autologous reconstruction utilizing deep inferior epigastric perforator flaps. This array of reconstructions is representative of the broad spectrum of options currently available in breast reconstruction.⁹ The length of time between reconstructive surgery and the post-operative interview ranged from 15 to 286 days, with the mean length of 108 days.

Thematic analysis and coding of the qualitative interview transcript data revealed patient perspectives and exposed potential inadequacies related to the content of information provided. Interview transcripts allowed researchers to obtain 12 general themes of which 8 related to the content of information desired: the pros and cons of reconstructive options, post-operative recovery and expectations, availability and consequences of immediate breast reconstruction, nipple-sparing mastectomy, oncologic safety/monitoring and prophylactic mastectomy reconstruction, secondary procedures, impact of chemotherapy and radiation, and managing relationships and intimacy issues. Representative examples of verbatim participant quotes are presented for each of the 8 themes to illustrate patient concerns. The other 4 themes related to information delivery preferences and were reported upon in an earlier publication.⁶

Pros and Cons of Reconstructive Options

Patients were often surprised that breast reconstruction is complex and that so many options are available. As one woman put it, "I thought I'd just be told you're getting this or that. I had no idea I'd have all these options to consider." Areas of particular interest included comparing breast reconstruction procedures, level of time commitment necessary to complete the reconstruction process, complications, final appearance, and deciding on unilateral versus bilateral reconstruction. Faced with so many options, study participants indicated that they were interested in knowing the pros and cons of each option—"I'd want it

all broken down into most likely, least likely, rare, . . . a comparison so you could chart recovery time, complications. . . Then you could make an informed decision of what you'd like to do."

In terms of reconstruction employing a tissue expander, participants would have liked more information on the number of office visits required for expansion and the expected length of time until insertion of the permanent implant. These details may impact a woman's surgical choice, given her personal lifestyle, goals, and responsibilities. Although most participants understood that a second surgery was necessary when tissue expanders are part of their reconstruction, in the case of post-operatively expandable implants, some "didn't realize I would have to have a second surgery to have the port removed." This demonstrates the need for all aspects of the reconstruction process to be clearly laid out.

For some, the length of surgery coupled with potential complications could be a deciding factor. One woman voiced her concern about autologous reconstruction—"I didn't want to be put through that length of surgery and the extent of the surgery and face the fear of flap loss." Women are considering multiple concerns and goals, as they make a decision that is best for them.

Final appearance was also a concern. Desired information ranged from wanting to know where the breast(s) will sit on the chest wall: "More information should be given to prepare you for where the expanders and the implants will be sitting on your body and what's normal and what's not." Others wanted to know what they should consider when choosing a unilateral versus bilateral procedure: "I think you should also tell women who . . . don't have both sides fixed up how hard it can be then to find bras that fit and are comfortable and how it makes clothes so difficult." Given the range of concerns and deciding factors that are at play, patients required wide-ranging and extensive information about pros and cons in order to make a decision that integrates a variety of concerns covering the pre, intra, and post-operative periods.

Post-Operative Recovery and Expectations

Information pertaining to management of the postoperative recovery period was important to the informants. Depending on one's responsibilities and lifestyle, this period could require significant preparation and organization. As such, clear information should be provided so women know the extent of lifestyle modification that may be necessary. One woman stated that she thought there should be:

[m]ore emphasis and information on what to expect post-surgery. Like the fact that you can't take care of your children on your own for a good two to three weeks. Also, things like you can't lift, you can't carry, you can't raise your arms, and you have to sleep on your back.

In fact, unanticipated sleeping challenges were a prominent theme among respondents:

Having to always sleep on your back is harder than you think and I'm very tired as I don't sleep well.

And:

I had no way of getting out of bed. My husband ended up going and renting a lift chair and I slept in that.

The effects of anesthesia were also unanticipated by some informants who noted that:

I find that especially after surgery my mind isn't as clear as usual and it's easier to forget things or not remember what you were told.

Although not necessarily considered an aspect of the reconstruction itself, cognitive dysfunction can be part and parcel of the surgical experience and should not be overlooked in the information transfer process.¹⁰

Post-operative wound care and appearance was another area of concern. Given that this may be the first time a woman has had surgery or an incision, she may be unsure what constitutes a healthy versus concerning incision:

I took off my steri-strips and had, what looked like a lip, and I was freaked out wondering if it would stay that way and if it was normal. It's gone now but I didn't know if that was normal... or it needed to be seen by a doctor.

Some women would have appreciated candid photos to help them determine what is "normal" and what is not so that they could better identify signs of infection or necrosis or could have been reassured that their breasts looked as they should at this point in recovery.

Patients were often surprised by the sensations they experienced throughout the recovery period such as, "itching," "zinging," "zapping," "tightness," "muscle spasms," "tingling," "burning," and "shooting" pains. They had not expected these sensations nor did they know if they were something to be concerned about:

When you're trying to be meticulous and you're worried at home, it's like 'Is this normal?' That was the big question, 'Should I be worried about this?'

While some expressed acceptance related to post-surgical pain—"if you're going to have surgery, you're going to hurt", others related that, "I wasn't expecting it to be painful this long," and that, "it takes a long time to feel normal again." Preparation regarding what might be experienced in the course of healing and recovery was important to the informants.

Informants offered suggestions to support patients during this period:

I think a symptom checklist for after surgery would be really good – something with a pain scale and that refers to where you might be feeling pain would be good and would reassure you that it's normal and when to see a doc.

Also, information would be appreciated regarding "everyday things" like, "showering or cleaning or stuff like that." One woman also suggested that staff, "show [patients] where her [expander] port is and what it is" as she may not otherwise recognize what this hard spot is and unnecessarily worry.

Immediate Breast Reconstruction

The availability of immediate breast reconstruction was an important topic. Several respondents indicated that they were initially unaware that immediate breast reconstruction was a possibility. In some cases, the topic had never been introduced by their oncologic surgeon. For those who were made aware of the possibility, they expressed gratitude and a conviction that this should be routinely discussed:

The one thing I'd really like to emphasize is the importance of offering women reconstruction at the same time as their other surgery. That seems so important to me. I really think that should be more available. It has been so helpful to me to have that all at once.

For some women, the availability of immediate reconstruction alleviated concerns over their sense of femininity: "I couldn't imagine living without breasts. It's part of being a woman, I think." Others opined that, "I adjusted much better psychologically than I would have if I had had to wait for delayed." For others their concerns were around minimizing subsequent surgeries: "I finally decided that I wanted to do immediate reconstruction because I didn't want to continue with further surgeries." Having a plastic surgery consult as part of cancer care was also noted as having an impact on treatment choice "[b]ecause we were immediately sent to a plastic surgeon, we were in that stream. So you had all the options in front of you from the beginning." Having one's options laid out, minimizing the number of surgeries needed, and maintaining a sense of bodily integrity were important priorities.

Nipple-Sparing Mastectomy

Recent awareness of nipple-sparing mastectomy as part of breast reconstruction sparked interest from informants. In light of a celebrity publicizing her own nipple-sparing reconstruction, this has brought greater attention to the topic: "We were interested in nipple sparing because we saw that Angelina Jolie had that." Informants wanted to know whether this type of surgery was an option for them and what the possible oncological ramifications might be: "I asked 'what are the chances of getting breast cancer if I keep the nipples?'" Given that there can be oncological concerns with this type of reconstruction and it is a newer procedure, participants suggested that it might be useful to have a simultaneous consultation with the breast and plastic surgeon, "in one room and discuss things together," so that the patient could know her options and the oncological implications. Informants were also interested in information

regarding the aesthetic results of this type of procedure and requested images because, “if I could have seen the nipple going versus nipple sparing, that might have altered my decision too or it would have just educated me more.”

Oncologic Safety/Monitoring and Prophylactic Mastectomy Reconstruction

Oncologic safety and monitoring in the setting of breast reconstruction was of concern to most informants and they wanted accurate information about the risks—“I think mostly I was concerned about the ability to check for cancer afterwards.” It was noted that misinformation exists and needs to be countered with fact: “Everybody says ‘oh, with an implant we can’t check for cancer’ and that’s not the case. They can still check for cancer.”

Bilateral reconstruction was also a consideration not only for those who have a genetic disposition to breast cancer but also for those who felt uncomfortable with retaining a natural breast after a cancer diagnosis in the other. Most women were the ones to introduce this topic during their plastic surgery consultation. A consensus statement guides plastic surgeons in their counseling of women seeking contralateral mastectomy and reconstruction. For some women, contralateral mastectomy and reconstruction may be clinically indicated,^{11–13} (ie, women with genetic mutation or those who are anticipated to have difficulty achieving symmetry after unilateral mastectomy) although discussion of the increased risk of operating on both breasts and the inability to guarantee symmetry needs to be undertaken. Although contralateral mastectomy is rarely recommended for women with unilateral breast cancer, a respect for patient autonomy must also factor into patient care, thereby making this an important part of breast reconstruction consultation.^{12,13}

In considering prophylactic reconstruction, informants noted that the availability of breast reconstruction played into their willingness to sacrifice their natural breasts: “I don’t think I would have had the courage to go ahead and do it prophylactically if I didn’t know that option was there.” The situation was similar for those who had cancer in 1 breast and were considering their treatment options: “The big decision for me was having a double mastectomy.” Information regarding the availability of bilateral breast reconstruction in the face of hereditary risk or unilateral disease diagnosis was important for women as they navigated their own goals, desires, and sense of self.

Secondary Procedures

Breast reconstruction can involve a number of secondary procedures that patients may not be aware of. Study patients wanted to know more about secondary procedures, including contralateral balancing operations and nipple reconstruction. Many were surprised to learn that these insured services do not require patients to pay out of pocket in the Canadian health care system. With regard to balancing procedures (augmentation,

mastopexy, and reduction), many reported, “I did not know about [balancing procedures] until I was offered it. I had no idea. I was pleasantly surprised” and “I thought they’d just do this one [mastectomy side] and that was it.” They were, however, well aware of the difficulties inherent in mismatched breasts:

Well, before I had the other breast lifted, I found it really hard to dress. One breast sat so much lower than the other and I had to wear about 3 layers of clothes just to hide that. It can be really hard to find bras that fit too.

The option of having one’s contralateral breast altered to more closely resemble the reconstructed breast was welcomed even if it did require further surgery and was not related to disease mitigation: “I said ‘ok, that’s another surgery but I’ll go for it.’”

With regard to nipple reconstruction, women wanted information ranging from where and how to get the procedure done, to the realities of living with a reconstructed nipple. One woman stated that she thought, “people should know more about nipple reconstruction and why or why not to do it and about the fact that it won’t have sensation.” Another noted she was curious about, “where they get the skin from to build the new nipple,” and whether a skin graft was necessary for this procedure. It was not uncommon for the study informants to be unsure of where to get their nipple reconstruction and tattooing done: “I already knew about nipple reconstruction, so I brought it up. I asked where I could get that.” Some patients were happy to have this done by their plastic surgeon while others were seeking other options, such as experienced tattoo artists, but they needed the information as to what was available and possible in order to make an informed choice.

Impact of Chemotherapy and Radiation

Patients were uncertain how chemotherapy and radiation therapy affect breast reconstruction options and results. They wanted more information about how these therapies influence what procedures can be offered, when they can be offered, and how they can impact the outcome of their reconstruction. Radiation was the biggest concern, as it most directly affects reconstruction options and results. Informants worried “about what will happen if radiation is needed.” Many were pleased with the information they received: “They kind of took me through what the options were and explained with the radiation damage what I could do.” Others were “surprised that since it was so long since I’d had my radiation that I was still considered complicated.”

When it came to chemotherapy, as with many other aspects of breast reconstruction, having the opportunity to speak with someone who had been through the process was very much appreciated.

Probably the most useful person to me was a friend who had had chemo and then reconstruction. She was very helpful on telling me what to expect at each stage and to answer my questions.

Managing Relationships and Intimacy Issues

Women wanted more information about managing close personal and intimate relationships post-reconstruction. They not only wanted information for themselves but also for those they were in close relationships with, including children and spouses. Some “consulted a psychologist in private practice on how best to talk to my children about this,” and others mused that “maybe it would be good to have some information about emotions men might experience and how to deal with these, as well as how to support their wife through all this.”

When it came to intimacy, the informants were concerned with how their altered appearance might affect these relationships. One informant put it succinctly: “I wanted to look pretty for my husband; that was my concern. I wanted to look sexy again.” Another worried that, “there’s not a lot of breast tissue left so, you know, cosmetically . . . I think about my poor husband and how horrifying it must be to look at this.” Information on navigating issues around body image and intimacy would be welcomed by many of the women consulted. Those in established relationships recognized that, some partners worry they’ll do the wrong thing. They wonder if they should look or if they shouldn’t; should they touch or not touch. Sometimes emotions come up that they don’t expect. As such, the informants expressed that there should be information geared to the intimate partner to help him or her adjust to their partner’s new appearance as well as information for the woman who has undergone the reconstruction. For those not in an intimate relationship but open to the possibility, their new body can cause them some anxiety: “I’m a single mom so I don’t know how that works to get in a relationship with someone again and your body image changes and that kind of thing.” Information guides, support tools, or access to workshops geared to addressing such issues might offer suggestions as to how to navigate such sensitive topics.

Discussion

Breast cancer surgery is not only physically invasive but can also be emotionally traumatic and lead to increased levels of self-reported distress during the survivorship stage of cancer treatment.¹⁴ Breast reconstruction has been shown to improve body image, quality of life, and psychosocial outcomes for women.²

Unfortunately, there is a gap between what women want to know about reconstructive breast surgery and the information they receive.¹⁵ Patients diagnosed with or having a strong family history of breast cancer need comprehensive and relevant information early on and through their treatment process in order to make well-informed decisions.^{16,17}

The results of this study have demonstrated that women have extensive information needs when it comes to planning for, undergoing, recovering from, and living with breast reconstruction. Making decisions about breast reconstruction can be overwhelming and complex for patients due to the number of reconstruction options available. Patient preferences and personal values also vary and influence decisions.¹⁸ Confounding these challenges is that women sometimes need to make their choices promptly at a time when the diagnosis of cancer preoccupies their attention. Research indicates that the probability that a woman will experience post-operative decision regret and depression rises with her dissatisfaction over the information transfer process.¹⁹ The findings from this study provide an opportunity to develop education materials targeted toward identified information gaps. As new procedures are developed, particularly those that gain public attention, special attention should be directed to addressing these issues during the information transfer process, as the patient needs to understand the options and consequences from an experienced professional rather than the media.

Oncologic breast health professionals do not always inquire about patients’ interest in breast reconstruction or refer them for a reconstructive consultation, thereby missing an opportunity to provide information early.^{5,20-26} Patients are often surprised by the variety of types of breast reconstruction options available and may be unaware of their suitability for breast reconstruction altogether.²⁴ As previously reported,⁶ BREAST-Q sub-score results suggest that patients in this study were somewhat dissatisfied with the amount and quality of breast reconstruction information they received. These findings span all forms of reconstruction, despite the intense efforts to educate patients and comparatively higher satisfaction scores for the quality of the plastic surgeon, medical team, and office staff.

Routine breast reconstruction consultations of superior quality must become standard if women are to be fully informed and apprised of all of their options and referrals to a qualified plastic surgeon should not fall to the patient to initiate.^{4,27} Given that breast reconstruction is an elective procedure that requires a significant amount of information transfer and that studies have shown that patients forget up to 80% of the information delivered in the physician’s office,²⁸ it is important to offer wide-ranging content in a variety of formats. In the practice of the surgeon involved in this study, patients are given written and electronic information, 2 presurgical consultations that routinely run to nearly an hour each and are offered a phone call from a peer volunteer who has been through reconstruction. When physicians spend the time and effort to foster an atmosphere of trust and collaboration with a willingness to employ a multimodal approach to adequately educate patients and answer their questions, greater patient confidence, and satisfaction results, which is favorable for both parties.^{3,29-31}

Despite the variety of patient perspectives illustrated in the 8 overarching themes from this study, information that meets patient needs is critically important.²⁷ Efforts must be made

to offer patients comprehensive information in order to improve patient care.^{21,22}

Limitations

The study was a predominantly qualitative study limited to a single surgeon's practice. As such, it does not reflect all breast reconstruction options available today. Further, given that the surgeon's practice is primarily immediate breast reconstruction, delayed breast reconstruction informants were in the minority. Although the BREAST-Q was administered to all informants, the small sample size did not allow for statistically meaningful results, particularly if parsed out by patient or reconstruction type. Additionally, although thematic saturation was reached in the study responses, responses were not parsed out according to patient or reconstruction type as the sample size was too small for this to be meaningful. This is a qualitative study that examines a contextualized surgical practice and patient responses to the types of information they received and/or desired with regard to breast reconstruction. The findings may not be generalizable but do offer insight into the types of information that women are interested in and point to the importance of quality information transfer to ensure quality shared decision-making in the breast reconstruction setting.

Conclusions

By listening to women who have recently had breast reconstruction surgery, we are able to discover important insights into their information needs and to determine specific areas where patients believe information is currently lacking. In order to improve patient satisfaction, comprehensive information can be targeted to improve patients' ability to make informed decisions prior to surgery and to transition more comfortably to the post-intervention period.

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