



CARTAS AL DIRECTOR

Reduction mammoplasty technique. The pheasant tail nymph of the oncoplastic



La técnica de reducción mamaria. La ninfa faisán de la cirugía oncoplástica mamaria

Dear Editor:

If you asked an experienced trout angler to choose a sole fly whenever they go fishing they would probably choose a “pheasant tail nymph” because it catches trouts in all types of rivers in a wide variety of situations. Similarly, which surgical technique should an oncologic breast surgeon add to their repertoire if they want to perform modern breast cancer surgery? The answer is the reduction mammoplasty (RM).

Despite the wide range of oncoplastic breast conserving techniques (OBCS), nowadays, after twenty years of oncoplastic surgery development, the use of a tumour adaptive RM is considered a current standard procedure to treat breast cancer conservatively¹ and is clearly the most frequent of OBCS.² This is because RM is a versatile technique that allows the surgeon to remove a tumour located in any quadrant of the breast with only one of the following two conditions to be met: either moderate or large breast size, or enough breast inferior pole to remodel (ptosis). In addition, the technique is safe and effective oncologically, with an acceptable morbidity rate, good cosmetic outcomes and high patient satisfaction scores.³

Consequently, this is clear that RM is a useful and indispensable technique. The surgeon who handles it can perform OBCS and symmetrization of the contralateral breast, in the context of a conservative treatment or in the process of postmastectomy breast reconstruction. RM combines many surgical steps which are the basis of the rest of most OBCS such as desepithelialization and transfer of the nipple areola complex and allows the surgeon to perform many different oncoplastic techniques that are RM variations, for example, *batwing* and *raquet mastopexy*.

As we all know, there is a lack of oncoplastic training with evident barriers to access to learn and incorporate these surgical techniques into a breast surgeon's practice. A survey conducted by the Oncoplastic Surgery Committee of the American Society of Breast Surgeons with 708 respondents (representing 26% of active practice membership) showed that a minority of respondents reported having breast reductions performed independently (19%) or contralateral symmetry (10%).⁴

OBCS can be classified into three levels according to the extent of skill and training required to perform each of these procedures, although the amount of training needed for competency has not yet been standardized. In this classification, it seems to be implied that the direction of learning goes from level I to III. In my opinion, if the surgeon learns RM in the first place or at the same time as other techniques, it is easier than if they struggle to advance from the inferior level I, and stop when they reach RM, which is usually considered as a limit or a speciality frontier. The critical point is how to learn RM.

One of the possible responses is the incorporation of the treatment of symptomatic macromastia in breast units, which offers two advantages: increasing the insufficient supply for patients with large breasts suffering from symptomatic macromastia and enabling the training in reduction mammoplasty techniques for breast surgeons.⁵

References

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