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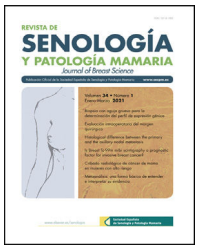

OPINION ARTICLE

Oncoplastic breast-conserving surgery. Where am I?, On one side of the pendulum?

Cirugía oncoplástica conservadora de mama. ¿Dónde estoy?, ¿A un lado del péndulo?

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An article recently published reported that quality of life (QOL) and patient satisfaction with esthetic outcome were prioritized by a large and representative panel of world-renowned breast specialists as the two highest outcomes in oncoplastic breast surgery (OCBS) being critical for decision making in breast surgery. From this panel it emerged that ''OCBS should be recommended versus standard breast conserving surgery (BCS) for the treatment of operable breast cancer in adult women who are suitable candidates for BCS with a very low level of evidence'', this was strongly supported by 36% of the panelists. Some of the limitations of the article stated by the authors were the paucity of quality publications and the fact that despite the relevance of these outcomes they were excluded from most of the studies comparing OCBS versus standard BCS which were revised and analyzed.[1]

Since the first articles[2,3] demonstrating the advantages of OBCS in compliance with oncologic surgical principles, many studies have been published – mostly single-center restrospectives cohorts – demonstrating that there is no difference between both surgical approaches in terms of oncologic safety with level IV of evidence. However, it is generally accepted, and frequently written, that well designed prospective multicenter cohort studies with propensity-matched outcomes evaluated using standard tools are needed to add more and best evidence in this field on QOL.[4]

I would like to make some comments on the above remarks. In the late 20th century and early 2000s, when the OCBS started with the novel use of some plastic surgical techniques to treat breast cancer – without distinction between the oncological and the esthetic parts – the main reason was to ameloriate or fully achieve the goal of breast conserving treatment (BCT) – surgery plus radiotherapy–, the cure of the patient with the preservation of a cosmetically acceptable breast avoiding the bad cosmetic or severe sequelae which affected around one third of the patients treated with BCT.

Although OCBS has had an uneven development worldwide and in the same country among different breast units as a result of the lack of access to well-structured training in OCBS, which is at the border of different specialities; one thing is indubitable, OCBS has progressively been spreading in all breast units because breast surgeons have experienced the same, improved cosmetic results of BCT since the emergence of OBCS.

OBCS is more frequently used in patients with large tumors, with a mild response to neoadjuvant chemotherapy or with multifocal lesions requiring large excision, and consequently, in patients who are at risk of having breast cosmetic sequelae. In other patients, for instance, with early stage unifocal breast cancer located in favorable quadrants, such as the upper outer quadrant, OCBS might result in overtreatment because a standard lumpectomy (SL), which is a less complex surgical procedure, can obtain a good cosmetic outcome. The surgical decision is a very complex process where many aspects play an important role,

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e.g., the range of available surgical techniques, surgeon and patient preferences, patients conditions, etc.

In our breast unit where oncoplastic techniques are available the comparison between standard lumpectomy (SL) vs OCBS showed that there were no differences in all Breast-Q domains. Satisfaction with breast domain, which is clearly related to cosmetic outcome depending on the surgical technique, was the same in both approaches. A plausible explanation might be that the OCBS approach improves the outcome of the SL by avoiding treating patients at risk of cosmetic sequelae if they are treated with a conventional lumpectomy.[5] In my opinion, considering SL and OCBS techniques separately blurs the perspective, both are just only techniques in the same field, the breast conserving surgery. I agree with some breast cancer specialists who are skeptical about the need for formal evidence-based validation of OCBS; it could be considered simply a variant form of breast conserving surgery.[1]

On the other hand, I have reservations about the possibility of conducting a robust article – a study in which patients are randomly assigned to the treatment or control group and are followed prospectively – which could give us the highest level of evidence. I will raise only two of the possible hurdles. If the OCBS approach is available in the breast unit the random selection of patients has ethical limitations, to avoid this and to match the patients treated in the two approaches, they must come from different centers-some of them without oncoplastic training where only SL can be offered. In that case, currently, the problem is to find these centers, because this situation is becoming increasingly more rare.

Bearing these considerations in mind, I propose that an oncoplastic approach should be appreciated for its side effects (externalities), such as a reduction in the percentage of reoperation for affected surgical margins, the increment of the percentage of breast-conserving surgery avoiding mastectomies with difficult breast reconstruction (extreme oncoplastic approach) and the improvement of cosmetic results of a conventional lumpectomy, minimizing the risk of severe esthetic sequelae. Therefore, more purposive than comparing SL versus OCBS or evaluating OCBS separately, it would be to determine a *''standard range of percentage of oncoplastic conserving approach''* in which patients were treated correctly with simple lumpectomy, reserving more complex and extensive surgery for patients who really needed it and avoiding overtreatment on the condition that this mix of BCS obtains good outcomes.

I would like prestigious colleagues to take up the challenge of setting this standard. If so, I could answer the initial question Where am I?, on one side of the pendulum?.[6]

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