

ONCOPLASTIC TRAINING AND ETHICS

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Breast cancer surgery had a major progress and now it must be carried out with a special attention to cosmetic results and the quality of life of the patients. Disfiguring and mutilating surgeries can no longer be biologically nor oncologically justified for patients under screening programs. In this way, oncoplastic surgery (OP) represents both an evolution and a final refinement in breast cancer surgery. Three important facts were considered as the main reasons for a change in current Breast Surgery training. The first one is that many breast cancer patients do not receive any kind of breast reconstruction due to unavailability of surgeons with OP background. The second one is that immediate breast reconstruction has better aesthetical results than delayed after conservative surgery and mastectomies. The third one, and perhaps the most important of them, is the cultural and psychological representation of the breast in our society. Patients with pronounced asymmetry after a breast cancer surgery are more likely to feel significantly stigmatized. They have more fear of death, increased psychosocial problems due to loss of their femininity, more depressive symptoms, and, consequently, more harm to their quality of life, independent of their chances of cure. So, this new arrangement is perfectly well justified. Breast Fellowship needs to expand the current curriculum in order to create a new specialist surgeon who performs all kind of reconstructions. Of course, a single surgeon carrying both oncologic and

reconstructive backgrounds requires special training in cross-specialty techniques to undertake all these procedures in the highest standard, and with new responsibilities and new medico-legal implications. Until now there is no formal training of breast surgeons in breast reconstruction techniques and there are many individual contrasts over the country. Competences in perform these surgeries need to be graduated in a specific classification in order to organize training opportunities. The new classification proposed is based in different levels of competences:

- Level I – Monolateral and displacement techniques: aesthetic skin incisions, deepithelization of the areola margins, glandular mobilization and reshaping techniques, purse string sutures for central quadrant reconstruction.
- Level II – Bilateral and replacement techniques: breast reduction (inferior and superior pedicles, and round block techniques), mastopexy, Grisotti flap, nipple and areola reconstruction.
- Level III – Expander/Implants techniques: immediate breast reconstruction with temporary expanders or implants, and contralateral symmetrisation.
- Level IV - Autologous flaps techniques: pedicled or free flaps, or combination of techniques.

It is necessary to ensure the safe introduction of OPS into surgical practice. Breast surgeons have two important aims to address in this new reality: to perform a good local control of disease and to focus in the quality of life of all breast cancer patients. And the quality of life is a matter of breast surgery decisions in the moment of breast cancer diagnosis. So the

curriculum of breast surgery must expand their limits and their responsibilities in order to better change the reality of breast cancer patients.