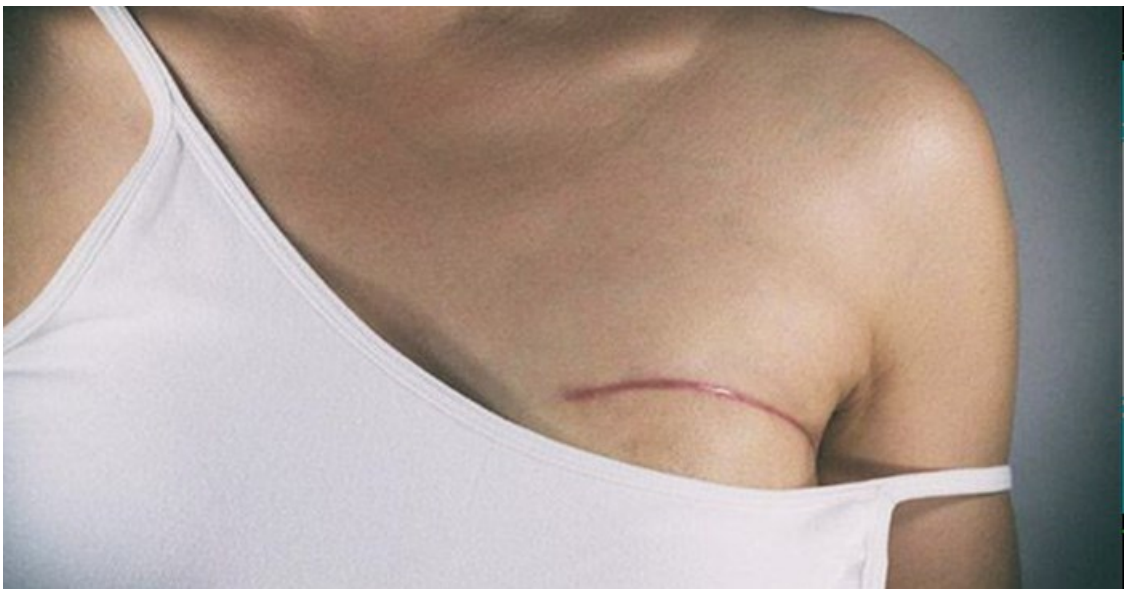
A multidisciplinary team approach in managing breast cancer

The concept of a team approach between specialists is important for the best possible clinical outcomes for breast cancer patients. Professor Frank Graewe explains why.



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What do you believe is important for patients to know before they come for a consultation?

There are a few important facts that patients and the referring doctors are not always aware of. Firstly, good communication between the different members in a multidisciplinary team treating breast cancer patients is crucial to achieve the best outcomes in terms of cancer survival and control as well as the cosmetic outcome following breast cancer treatment and reconstruction.

This can be achieved either by seeing and evaluating patients together during combined breast meetings or to discuss the specific patients treatment requirements and decide on a combined treatment plan. Traditionally patients that have been diagnosed have been referred for surgery, then after the surgery they would consult with the oncologist and lastly when surgery, chemotherapy and maybe radiotherapy have been completed they would get referred to see a plastic surgeon for a possible reconstruction.

This approach was supported by several myths that we now know are false. Clinical evidence and published research data has confirmed that breast reconstruction does not increase the risk for breast cancer recurrence. It has further been proven that immediate breast reconstruction is a safe and appropriate choice for breast cancer patients. Research on cancer recurrence and reconstruction has been divided and clouded by hypothesis and scientific interventional studies that claimed that reconstructive surgery leads to a local environment and inflammatory changes that during laboratory experiments showed increased cancer cell activity. Clinical evidence however showed that reconstruction is safe and has no negative effect on recurrence rates and prognosis.

Secondly, most medical aids do pay for breast reconstruction procedures according to their scale of benefits. Frequently patients seeking help in the form of breast reconstruction surgery are under the impression that medical aids perceive breast reconstruction as cosmetic procedures and these procedures don’t qualify for medical benefits. That is not true, medical aids do cover breast reconstruction if the diagnosis of breast cancer is confirmed by a pathology report following histologic examination of the specimen.

What kind of multidisciplinary team should a patient be looking for?

The members of a multidisciplinary breast cancer team should include a number of different specialties to provide best outcomes. Radiologists, to assist with imaging in diagnosis and decision making, oncological surgeons to perform cancer surgery and plastic surgeons to perform breast reconstruction surgery. Pathologists for histological examinations and radiation and medical oncologists to plan and deliver the necessary adjuvant therapies either before or after the surgery. Interaction between these specialists and input from each team member should aid decision making and will contribute to the best clinical outcomes for each patient. Recently genetic testing has become an important additional tool to further improve the decision making process.

Holistically, the journey a patient follows may differ according to the type of cancer and staging of their cancer. The question is, who decides on this journey?

The best decisions emerge from combined team members depending on the before mentioned factors. Advanced breast cancers for example can benefit by first receiving neoadjuvant chemotherapy before any surgery and the necessity for post mastectomy radiation can impact on the reconstruction. In some cases this might impact the choice and even timing of reconstruction.

What may influence decisions for patients needing to make a decision on a double or single mastectomy?

Double mastectomies are indicated in patients with a high risk to develop cancer in the other breast like in patients that carry a genetic predisposition for breast cancer or if there are malignant or premalignant changes in both breasts. Both the surgery to remove breast tissue and the reconstruction is more extensive but can be performed safely in the majority of cases.

In reconstruction, what are the things to consider when deciding on immediate reconstruction vs waiting and having reconstruction done later?

A very important factor to consider is the patient's autonomy in deciding on performing the reconstruction immediately or at a later stage. In theory the majority of patients can have immediate reconstructions, even if radiotherapy is indicated after surgery. But for some patients the burden to take that decision is just too much and all they want after learning of having cancer is to get rid of the cancer and to go on with their lives. In some instances patients might have medical conditions or factors that delay the reconstruction. Other patients might not want a reconstruction or are not sure whether they want one and then it is better to go ahead with cancer resection only.

Can the decision to have radiation and chemo after surgery affect the timing of reconstruction?

Yes, generally during chemotherapy, surgery is not indicated and can only be planned after about 4 weeks after completion of chemotherapy and that will delay reconstruction for at least 6 months. Surgery should be delayed for at least six weeks after radiotherapy to allow a sufficient time period for the acute changes to settle.

- ***What are the options for a patient when considering reconstruction – does it depend on the extent of tissue removed?***

It does depend on the extent of tissue removed, the location of incisions and scars, the size and shape of the normal breast, the necessity of radiotherapy after mastectomy, the specific body habitus and anatomy of the patient and again lastly and importantly on what the patient wants.

- ***What are the potential risks for reconstruction and how can the doctor and patient work together to reduce these risks?***

The preoperative evaluation, risk assessment and informed consent is absolutely crucial. Reconstructive surgery carries the same risks as any other surgery and specific risks that are associated with the type of reconstruction. The decision to do an implant based or own tissue reconstruction has an important influence on potential risks. Discussing these risks in detail, will empower a patient to better cooperate with the surgeon and to assist in active prevention of complications. A well informed patient will be better equipped to prevent risky behaviour and to recognise early warning signs of any unplanned complications.

- ***What do you wish each patient knew when they come to you, to reassure them regarding the process?***

First of all I want to equip the patient with knowledge to understand their condition, the proposed management and surgery, as well as reconstructive options. Secondly I can assure them that I have sufficient experience in reconstructive surgery and that I can offer them a variety of different options, be it implant or expander based or autologous reconstruction with their own tissue, including newest state of the art microsurgery techniques using abdominal, gluteal or thigh flaps. The patients should be able to be informed and to be actively involved in this decision making, with the reassurance of an experienced and professional team taking care of them. And should they be overwhelmed by the diagnosis of cancer and not be able to face a lot of decisions that they can trust and rely on a professional and empathetic team to take care of them.