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LETTER TO THE EDITOR

Recommendations for an Effective and Safe Extreme Oncoplastic Breast Surgery Combining Multiple Techniques

Gianluca Franceschini, MD

Sir,

I greatly appreciated the article by Jean-Claude D. Schwartz[1] and would like to propose further recommendations to improve outcomes and overcome the limitations of extreme oncoplastic breast-conserving surgery (eOBCS) when using multiple techniques.

EOBCS includes a set of oncoplastic surgical techniques that allow breast conservation in patients with generally large or multifocal/multicentric cancers who would otherwise be candidates for a mastectomy.[2]

However, it should be emphasized that the trials reporting equivalence in terms of disease-free survival and overall survival between eOBCS and mastectomy are extremely few and exclusively retrospective, with all the limitations of these, such as unclear inclusion criteria, inhomogeneous treatments, limited number of patients, and short follow-up; well-designed prospective controlled trials providing rigorous evidence on the safety of eOBCS are not yet available.

Schwartz shows an interesting case of a breast cancer patient in whom three different oncoplastic techniques (the Wise-pattern split reduction, immediate nipple reconstruction, and autologous volume replacement) are used in one surgery to facilitate and optimize eOBCS.[1]

I fully agree with Schwartz that the future of eOBCS will depend on the continued creativity of surgeons in combining various techniques in breast reconstruction[1]; eOBCS is a highly specialized procedure that requires adequate and innovative surgical skills.

I nevertheless think that the technical dexterity alone is not enough to achieve a successful result; I believe that some specific recommendations should always be followed to improve oncological and aesthetic results when using eOBCS, such as[3,4]:

- Accurate local staging of the disease by clinical examination, mammography, ultrasound, and magnetic resonance to choose the best candidates for eOBCS;
- Precise radiological preoperative study to assess the extent of disease, localize multifocal/multicentric tumors and/or calcifications, by one of the available procedures (radioguided or magnetic seed localization);
- Multidisciplinary debate in a dedicated surgery committee to select the more appropriate eOBCS and reduce the risk of failure;
- Use of intraoperative ultrasound to calibrate the surgical resection and save as much glandular tissue as possible;
- Intraoperative radiological and histological study of the removed tissue to confirm the correct excision of all lesions and evaluate the resection margins;
- Systematic circumferential shaving of the tumor cavity to increase the probability of obtaining free surgical margins and minimize the risk of recurrence;
- Clinical and ultrasound assessment of the glandular tissue preserved at the end of eOBCS to rule out persistent macroscopic tumor residues;
- Placement of clips within the excision cavity as a marker to guide adjuvant radiotherapy;
- Use of oxidized regenerated cellulose in the breast surgical site as a hemostatic agent to control bleeding and as a filler for reconstructive purposes to repair the breast defect and improve the aesthetic results.[5]

Based on my experience, I strongly believe that the repetitive performance of the above tasks can be an additional tool to overcome the limitations of eOBCS and increase the chances of success in this complex surgical challenge.

Gianluca Franceschini, MD
Department of Woman and Child Health and Public Health
Università Cattolica del Sacro Cuore
Fondazione Policlinico Universitario Agostino Gemelli IRCCS
Largo Agostino Gemelli 8, Rome, Italy
Email: gianlucafranceschini70@gmail.com

DISCLOSURE

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From the Department of Woman and Child Health and Public Health, Università Cattolica del Sacro Cuore, Fondazione Policlinico Universitario Agostino Gemelli IRCCS, Rome, Italy.

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