# Oncoplastic surgery – Standard of care

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## 1. Introduction

Over the last decade the whole approach to breast cancer surgery has changed radically from its 'general surgery' roots. There are few surgical specialties that have changed so much. The initial phase was the attention to wide local excision surgery, employing a more sensitive take on breast conservation, with scar placement and parenchymal reshaping. Then the concept of avoiding mastectomy by means of more extensive wide tumour excision together with partial breast reconstruction led to a flurry of innovations involving volume replacement and displacement techniques [1]. Oncoplastic breast surgery as a specialty now encompasses all elements of breast cancer surgery: appropriate cancer resection, skin-sparing mastectomy and immediate breast reconstruction, the full elements of total and partial breast reconstruction and adjustment for breast asymmetry by augmentation, reduction mammaplasty or mastopexy for the contralateral unaffected breast [2].

The legacy of historical surgical training has meant that until recently few surgeons have been equipped to offer this cancer surgery/cosmetic/reconstructive breast surgery hybrid approach. This is changing with training initiatives. Over the last decade approximately 90 surgeons in the United Kingdom have undergone 1-year-long senior fellowships in oncoplastic breast surgery in nine tertiary centres, trained by both breast and plastic surgeons seamlessly. This approach is changing the quality of surgical care for the benefit of women. It has also led to a rejuvenation of breast surgery away from purely resection-based operations that had remained unchanged for many decades, to an innovative specialty with creative concepts and aesthetic detail. In turn, the result in the UK has been marked interest amongst trainee surgeons to enter breast surgery as a career, and applications for the national fellowships are highly competitive.

Nevertheless much breast cancer surgery is still delivered by general surgeons, so care for individual women may involve surgeons from general as well as plastic/reconstructive surgery backgrounds now working together in an 'oncoplastic multidisciplinary team'.

In 2007 extensive guidelines were developed in the UK to address inequalities in surgical provision. *Oncoplastic Breast Surgery – a guide to good practice* was a joint venture between the Association of Breast Surgery at BASO, the British Association of Plastic, Reconstructive and Aesthetic Surgery (BAPRAS), and the Breast Surgery Interface Training Committee at The Royal College of Surgeons of England [3]. This was intended to be for women with breast cancer, and all those involved in their care, to ensure the highest standards in setting up and delivering an oncoplastic breast service.

In 2012 the guidelines were revised and newly published, and constitute a fully comprehensive document describing high standards of care for all aspects of oncoplastic and reconstructive breast surgery. They also cover aspects of the processes, the patient's journey and arrangements for both equipment needs and team participants. The advantage of the revision is that the 5 years' experience in developing models of care has been incorporated by the multispecialty team of writers into the 2012 document. The UK document is unique in its ambition to raise surgical quality nationally, to ensure that patients are aware of what is available, and to inform surgeons, allied professionals and hospital administrators about what is required to provide a modern high-quality standard of care for women with breast cancer. These guidelines can be accessed online through either the Association of Breast Surgery or BAPRAS websites: 'Oncoplastic breast reconstruction – Guidelines for Best Practice, 2012, Eds Dick Rainsbury and Alexis Willet' (http://www.associationofbreastsurgery.org.uk/media/23851/final_oncoplastic_guidelines_for_use.pdf).

The role of surgery in the management of women with breast cancer remains all important and fundamental. Its role in the prevention of breast cancer for women at high risk by virtue of family history or gene mutation is increasing.

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## Conflict of interest statement

None declared.

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