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Does oncoplastic breast surgery have a future in Scandinavia?

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In recent years, breast cancer surgery has seen major developments. A new breed of specialized breast cancer surgeons, with the knowledge and skills to optimize both oncological and cosmetic outcomes, are redefining the central role of surgery in the management of breast cancer patients. For oncoplastic breast surgeons, these outcomes are inseparable

and because of this, they are likely to have a major impact on the quality of life of breast cancer patients. Oncoplastic breast surgery is receiving increasing interest within the European surgical community and it was therefore noteworthy to see no publication or discussion on this field in a recent issue of *Acta Oncologica* focusing on the last DBCG

meeting in commemoration of its 30th anniversary (volume 47, issue 4, 2008).

The repertoire of an oncoplastic breast surgeon is based on sound oncological principles and an appreciation and understanding of breast aesthetics. In a recent editorial in the *British Journal of Surgery*, Andrew Bailldam defined oncoplastic breast surgery as the seamless surgical approach to ablation of a breast cancer while concurrently undertaking partial or total breast reconstruction [1].

Studies have shown that a significant number of patients are dissatisfied with the aesthetic results following traditional breast conserving surgery and cosmetic failure is probably more common than generally realised [2,3]. Predicting cosmetic outcome following breast conserving surgery is therefore important and it is from knowledge of factors which impact on this outcome and application of techniques to optimise it, that partial breast reconstructive techniques have been developed. In general, these techniques involve breast-reshaping or volume displacement (i.e. therapeutic mammoplasty) or volume replacement (i.e. LD mini-flap) and frequently include contra-lateral surgery [4]. They often allow for wider local tumour excision, potentially reducing the incidence of margin involvement [5], without compromising cosmesis. The ability to excise a wider margin may be important in certain subgroups of patients (e.g. patients with DCIS). Also, this may allow excision of larger tumours that would normally be treated by mastectomy.

Total breast reconstruction performed by the oncoplastic breast surgeon may include the full scope of skin-sparing reconstructive options, from implant-based to pedicled or even free flaps (although this particular skill is likely to remain in the domain of the plastic reconstructive surgeon). Furthermore, risk-reduction surgery in high risk patients, either because of identified gene mutations or family history, will appropriately be treated by these surgeons in the future.

As the scope of the service provided by a breast surgeon with oncoplastic skills increases, the traditional link with general surgery is being broken. In the ABS at BASO (Association of Breast Surgery at the British Association of Surgical Oncology) 2008 year book, it is stated, that only 11% of newly appointed UK oncoplastic breast surgeons have elective general surgical practice and almost 40% do not have general surgery on-call commitments. Of the remaining 60% that are on the on-call rota, half of them voice concerns about continuing so in the long term [6]. In many ways, this is not surprising in the modern era of high patient expectations and medicolegal scrutiny, where justifying

doing the occasional laparotomy only when on-call can be difficult.

There is still a prevalent view of many within the European surgical community that the oncological general surgeon should solely be responsible for the cancer excision and the reconstruction should be handled by the plastic surgeon. As the inevitable evolution of breast cancer surgery continues, this view will soon be an historic one. Oncoplastic breast surgery as a subspeciality has been conceived by pioneer surgeons who have had the vision to appreciate that a cross-speciality approach to surgical treatment may improve outcomes. It must however be noted that there is a need for good quality research comparing the outcomes of oncoplastic breast surgery to traditional surgery. Most of the evidence to date is based on retrospective, single institution case series with relatively short follow-up periods.

The fact that oncoplastic breast surgery as a subspeciality sits somewhere between surgical oncology and plastic and reconstructive breast surgery, producing well constructed and focused training programs has been difficult. Many countries, mainly from central Europe and the UK have addressed this problem. In 2002 in the UK, the ABS at BASO retrieved government funding for nine oncoplastic fellows in England every year. The centres were chosen based on their ability to offer highest quality cross-speciality training. These fellowships have been open to senior plastic surgeons and breast trainees before the completion of their training and are offered on a national and competitive basis. Many of these trainees are now established consultants and as a result of this scheme the number of breast units offering oncoplastic breast surgery to their patients and local training in this field is increasing. In addition to this, the Royal College of Surgeons have in collaboration with ABS at BASO for many years held core and intermediate skills courses in oncoplastic and breast reconstruction surgery open to all breast and plastic trainees. As a result, learning oncoplastic techniques is now integrated into the training scheme of most UK breast trainees.

Oncoplastic breast surgery not only improves outcomes but offers women choice and fits well into a high quality, patient-orientated health care system. However, it can be technically demanding, time consuming and does need specialist training to learn and apply properly, which may have cost and resource implications for individual hospitals. This needs to be taken into account when establishing such a service.

The Scandinavian surgical community seems hesitant in taking part in this exciting evolution of breast cancer surgery and it has not published much

in the field of oncoplastic breast surgery. Cross-speciality training in this field is not being offered and in order to become an oncoplastic breast surgeon in Scandinavia, most trainees need to be dually trained in general and plastic surgery. This method of unfocused training may take far too many years to complete, many of which may be irrelevant to the trainee's needs. It is time to move forwards. Scandinavian breast units already offering oncoplastic techniques to their patients should strive to set up ambitious oncoplastic training programs. Furthermore, as the hype surrounding oncoplastic breast surgery may have been driven more by enthusiasm than evidence, the long academic tradition of the Scandinavian training system should put them in the forefront of future research in this area.

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Severe hyponatremia caused by hyperglycaemia due to interferon alpha therapy in advanced renal cell carcinoma

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To the Editor

Renal cell carcinoma (RCC) accounts for approximately 3% of all adult malignancies and 2% of all cancer-related deaths [1]. Palliative treatment options for advanced RCC consist nowadays of Interferon-alfa (IFN-alfa) in combination with bevacizumab and preceded by cytoreductive nephrectomy in good prognosis patients and of targeted therapy against growth factor receptors and vascular endothelial receptors in intermediate and poor prognosis patients [2,3]. The mean response rate of IFN-alfa monotherapy is 17%. Most frequently reported side effects of this treatment are fever,

malaise, myalgia, headache, anorexia and nausea. We report the history of a middle-aged man with a rare complication of IFN-alfa therapy.

A 59-year-old man was admitted because of fatigue, weight loss and anorexia. His medical history revealed hypertension, gout and a renal cell carcinoma of the left kidney 6 years ago, for which he underwent a tumour nephrectomy. Four years later a partial colectomy was performed because of local recurrence with extension in the flexura lienalis. Six months later a pulmonary metastasis was seen on a routine chest CT-scan. He was treated within the framework of a randomized phase