



Epworth Breast Service

Six Questions for Patients to ask their Breast Surgeon BEFORE they undergo their Breast Cancer Surgery



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Choosing your breast cancer surgeon is a very important decision, as not only may it influence the range of surgical options you are offered, but your breast surgeon acts as the "gatekeeper" to your entire specialist multidisciplinary breast cancer treatment team. The choice may be guided by your general practitioner and influenced by word of mouth recommendations. Research has also shown that women are increasingly themselves taking more personal control over choosing their breast cancer surgeon.

The first thing to emphasize is that the time to choose your breast surgeon is BEFORE your breast cancer surgery, not AFTER. This may seem very obvious, but too often I am faced with requests by patients to transfer their care after their surgery has been performed, which is too late, given that as a breast "surgeon" my training, specialisation and primary area of expertise is in performing the "surgery". These patients often state that they have felt rushed into their operation because they were given the impression that it was very urgent, and that any delays would potentially lead to a reduction in the chance of cure and they were understandably fearful that any wait may lead to the cancer spreading.

Below I have listed six questions which I hope may assist you in the important task of choosing your breast surgeon, together with some explanatory notes, and sample answers by myself in red.

1. Is there a rush for me to come to a decision about my breast cancer surgery?

The impact on the outcome/survival of delays in initiating treatment for breast cancer less than 90 days is scientifically questionable. The most thorough study on delay in initiating treatment for breast cancer was published in the Lancet in 1999, and this systematic review concluded that delays of more than 3 and more than 6 months probably do adversely affect survival by about 5/10% respectively at 5 years.

There is no general consensus on what constitutes an acceptable delay after a diagnosis of breast cancer and there is actually a reported trend in the literature for an increasing time interval between the diagnosis of breast cancer and surgical treatment over the last 10 years with many potential contributing factors. One large American centre published their experience over a ten year period, which demonstrated that time to treatment had significantly increased. Patients treated in 1998 waited an average of 21.8 days for operative intervention, those treated in 2003 waited 31.3 days, and those treated in 2008 waited 41.1 days. There are many reasons for this change over time.

Women are increasingly being actively encouraged to make considered, informed decisions about their treatment rather than being pressured into making snap decisions and more women are seeking second opinions. The increasing number of preoperative investigations including the proliferation of imaging modalities, particularly MRI, is also a factor. Preoperative fast-track genetic assessment is becoming more common in women who have a strong family history of breast cancer. Younger women may elect to see a fertility specialist for discussion of egg harvesting/IVF. The overall mastectomy rate is increasing, as is the rate of immediate reconstruction at the time of mastectomy. More women are also choosing to undergo preventive removal of the other "unaffected" breast and therefore overall more women are seeing a plastic surgeon to discuss reconstructive options. All of these factors contribute to the increasing time interval between the diagnosis of breast cancer and surgical treatment.

This is a good question to ask, as if you feel your breast surgeon is placing you under pressure to make an immediate decision, telling you that it is urgent that you have your surgery straight away, this should perhaps ring warning bells. If you are feeling pressured, maybe you should seek the opinion of another surgeon before you commit yourself to an operation. Breast cancer is not a medical emergency and very rarely is it clinically necessary to initiate treatment within days, or even within several weeks of the diagnosis. It is much more important to carefully consider and research important issues such as the appropriate breast surgeon and treatment options, rather than to rush into hastily made decisions.

Remember, the time to choose your breast surgeon is BEFORE you undergo your breast surgery; it's too late after the operation has been performed. There are always choices, and not all breast surgeons may be in a position to offer you the full range of surgical procedures - if you need an operation for breast cancer, you want it to be a good one.

2. Do you specialise in the treatment of breast disease only?

There is evidence that breast cancer patients treated by a specialist breast surgeon have better outcomes. A 2003 American study found that treatment by a specialist breast surgeon resulted in a 33% reduction in the risk of death at 5 years. Whilst the facilities for surgical training in Australia and New Zealand are among the best in the world, there is still an opportunity for breast surgeons to enhance their surgical skills by spending an extended period working overseas in order to gain the high volume operative experience not always readily available for young breast surgeons in Australia and to enable the acquisition of new surgical techniques, as well as broadening their overall vision of surgical practice. Ask if your surgeon specialises only in breast surgery. If you have a younger surgeon, checking the year they completed their surgical training may be a useful guide to ascertaining their level of experience. Also enquire if she/he underwent post fellowship training overseas, and for how long.

Jane O'Brien is a specialist breast and oncoplastic surgeon whose practice is exclusively confined to breast work, encompassing the assessment, diagnosis and treatment of all benign and malignant conditions of the breast, and surveillance and prophylactic surgery for high risk groups.

Following advanced surgical training at St Vincent's Hospital, Melbourne, which she completed in 1994, she undertook a two year breast surgical fellowship in Melbourne and Edinburgh, Scotland. She then worked as a specialist consultant breast surgeon in the United Kingdom for a period of eight years at a number of world class, internationally renowned breast units, during which time she gained extensive experience in advanced breast surgical techniques.

3. Do you have special training and experience in advanced breast surgical techniques?

This may not be a "deal breaker", but if your breast surgeon makes claims in their promotional material/website to have a special interest and experience in advanced breast surgical techniques such as oncoplastic breast surgery and nipple-sparing mastectomy, you may wish to substantiate the validity of these self-made claims. This can be fairly simply done just by enquiring exactly how many of these procedures they personally performed in the last twelve months. Surgeons with a genuine special interest and a high level of experience in these advanced techniques will usually be readily able to quote their approximate annual case numbers, and they are likely to be performing more than a couple of these cases per annum!

Over the last twelve months Jane O'Brien performed 20 cases of nipple-sparing mastectomies with immediate reconstruction, 11 of which were bilateral (double) mastectomies and also 11 skin-sparing mastectomies in conjunction with immediate reconstruction, of which 7 were bilateral. Over the same period she performed oncoplastic procedures in 19 cases in conjunction with breast conserving lumpectomy for cancer.

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Epworth Breast Service

Comprehensive Multidisciplinary Breast Cancer Management



4. How many new breast cancers do you treat per year?

Evidence has consistently and repeatedly shown that patients who are treated by surgeons with a higher caseload of breast cancer patients each year, have significantly better five year survival rates than those who are treated by surgeons who see fewer cases. As far back as 1995, a Lancet study examining differences in survival as a function of consultant caseload, demonstrated poorer results amongst those surgeons treating less than 30 new cases of breast cancer per year compared to those treating more than 30 new cases per year. A more recent 2012 Australian study found that the relative risk of breast cancer death was lower when surgeons' annual case loads exceeded 20 cases. Breast conserving (lumpectomy) vs mastectomy rates vary within and between countries for a variety of reasons, but most recent published figures reveal current average mastectomy rates in the range of 30-40%. The breast conservation rate is regarded as a quality measure in breast cancer surgery, and according to American Breast Centre Accreditation Guidelines, 50% should be considered as the absolute minimum breast conservation rate. Ask your breast surgeon their breast conservation /mastectomy rates to check that they are not way outside the accepted current normal range. If for example the percentage mastectomy /lumpectomy ratio were reversed, this should certainly raise concerns. Ask your surgeon how many breast cancers he/she treated in the last 12 months.

Jane O'Brien surgically treated more than 100 new breast cancers over the last twelve months. Her breast conservation rate over the same time period was 65%, with a 35% mastectomy rate.

5. Do you work as part of a multidisciplinary team?

A large body of international research evidence supports the view that outcomes for breast cancer can be maximised through a specialist multidisciplinary team approach. A multidisciplinary team meeting is a meeting attended by health professionals who discuss and develop management plans for each individual patient. International clinical guidelines for the management of breast cancer, including those of Cancer Australia, all recommend the promotion of multidisciplinary care, and this is an approach strongly supported by breast cancer consumer groups including Breast Care Network Australia (BCNA).

Does your surgeon practice as a 'solo' practitioner, functioning in professional isolation, or is he/she part of a single specialty group breast practice which allows for the knowledge exchange and shared decision making that comes with close day-to-day interaction with professional peers? (this is of more relevance for younger, less experienced breast surgeons) According to a 2004 Oxford Journal publication, patients perceive better service quality at group practices compared with solo practices on all dimensions of health care.

Ask your breast surgeon if all his/her breast cancer cases are routinely reviewed in a Breast Multidisciplinary Team Meeting and also how regularly the meeting is held, as meetings need to be frequent enough (preferably weekly) to allow prospective case review and thus the timely formulation of treatment plans.

The Epworth Breast Service is a group practice, and Jane O'Brien nominates all her breast cancer patients, with their permission, for discussion in the weekly Epworth Breast Service Multidisciplinary Team Meeting, which she established in 2005, where all cases are discussed both prior to and after their breast cancer surgery. Clinicians involved in this multidisciplinary team meeting include; breast surgeons, pathologists, medical oncologists, radiation oncologists, radiologists, nuclear medicine physician, MRI radiologist and allied health professionals including breast care nurses, oncology nurse coordinator, sonographers and radiographers.

6. Do you have a breast care nurse as part of your team?

The value of the specialist breast care nurse role as part of the multidisciplinary team in providing quality care for women has been increasingly recognised nationally and internationally as part of evidence-based best practice for breast care. Timely access to a breast care nurse can greatly assist women going through treatment for breast cancer and breast cancer patients repeatedly emphasise the importance of the role of their breast care nurses throughout their experience of breast cancer. The primary role of the breast care nurse is to support people who have or fear they have breast cancer, as well as their families and carers. They provide information, physical and psychological care and give practical advice to patients and carers from diagnosis to treatment, rehabilitation and beyond.

Breast care nurses have been available for over twenty years in Victoria; however access to a breast care nurse is sometimes variable and this has in the past often been particularly so in the private sector. Everyone affected by breast cancer should be able to access support from a breast care nurse. Ask your surgeon if you will routinely have access to a breast care nurse, and if this will be on an ongoing basis.

Jane O'Brien has two breast care nurses based in her consulting suites, who are available to all breast patients with either benign or malignant breast disease, for information, provision of educational resources, assistance with obtaining prostheses, psychosocial support and confidential counselling in a private, dedicated counselling room situated in the consulting suite. The breast care nurses visit patients daily during their hospital stay to spend some time and, importantly just to listen to how they are feeling. They provide appropriate information to help patients understand and adjust to what they are going through, help with any wound/drain care after the operation and organise support after discharge from hospital if needed.

Our breast care nurses are currently involved in the development and implementation of a tailored rehabilitation programme for our breast cancer patients after they have completed their primary treatment, with an 8 week pilot programme just completed. The aim of the programme is to assist patients in obtaining maximal physical, social, psychological and vocational functioning within the limits created by the cancer and subsequent treatment, and has physical reconditioning and psycho-educational components.

Copies of this information sheet may be downloaded from www.melbournebreastcancersurgery.com.au

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