Dr Julie Doughty, breast surgeon
Glasgow, Scotland

There is a common misconception that surgeons just carry out operations, says Julie Doughty. Nothing could be further from the truth. Surgery is only one aspect. The patient embarks on a journey, advised and supported by their surgeon, who is involved in the whole of their care. Good surgeons need to be good communicators. They must tell their patients what they need to know and ensure they understand, but they must not overburden them with more information than they want.

The diagnosis and treatment of breast cancer has changed dramatically within a generation. Thirty years ago many women who discovered a lump underwent surgery not knowing whether they would wake up without a breast.

Today, in the United Kingdom, over 99% of women know whether they have cancer before they go to surgery. They have discussed their treatment with their surgeons who will have planned their care. In the country’s symptomatic breast service, women are examined, imaged, biopsied and given their diagnosis on the same day.

“The incidence of women waking up to find a breast unexpectedly gone is thankfully in the distant past,” said Dr Doughty.

Breast surgery was one of the first areas of medicine to introduce standards for the quality of care, following the launch of the breast screening service in the late 1980s. The country was divided into 18 regions and performance was recorded – how many women went to surgery without a diagnosis, how many had lymph nodes removed – and compared.

“We tried to ensure everyone received good-quality care. Whether or not you believe in breast screening, its introduction has transformed how we treat patients with breast disease.”

As medicine has advanced and the quality of care has improved, survival rates have increased dramatically. But the incidence of the disease has also risen. With 50 000 cases of breast cancer in the United Kingdom each year and almost 12 000 deaths, the quality criteria have changed. Today, they include how many appropriate women receive chemotherapy and hormone therapy and how many women have reconstructive surgery.
Deciding what to tell patients about their prognosis remains a challenge. “If a patient has a cancer with a good outlook, then I will always tell them. It is important that they realize that they are more likely to die from being run over by a bus, and can lead a normal life.” “If they have a poor outlook, on the other hand, I will only tell them if they ask. I would never push the information on them. You must not destroy hope and everyone wants differing amounts of information.”

The breast is intimately bound up with a woman’s identity so achieving a good cosmetic effect following surgery is important – but never at the expense of safety. “The oncological treatment – removing all of the cancer – always takes priority. We would never compromise someone’s cancer treatment for cosmetic reasons.”

With survival rates now so good, the trend today is to target treatments to the women who will benefit and spare those who will not. In the past, if cancer was found to have spread to the lymph nodes, they would all have been removed. This can result in lymphoedema in some women – painful swelling, particularly of the arms or legs. Today, in many women, if after chemotherapy there is no sign of remaining cancer in the lymph nodes, then a smaller procedure, a sentinel node biopsy, is performed. If this shows that the chemotherapy has destroyed the cancer then the women are spared having all the lymph nodes removed and the morbidity associated with this.

“We want to select women who will benefit from specific treatments and try and minimize long-term morbidity. The trend is to better targeting of treatments – less is more.”

Yet many women, hearing the word “cancer”, demand more treatment than they need – often out of fear. They want the whole breast removed. Some go further and ask for both breasts to be removed, believing – wrongly – that that will prevent the cancer coming back and they will be cured.

“We have to persuade them that the treatment we are offering is the best. Quite often they disagree – they say, ‘You are denying me the safest treatment.’ So it can be a difficult conversation.”

“We are not being paternalistic but we are trained to give an opinion and that is what we must do. It is the patient’s absolute right to refuse our advice but it is our duty to give it. We have to practise evidence-based medicine.”

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