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The circle of life

I was considering material for the privilege of writing this guest editorial on breast cancer in South Africa (SA) while strolling the streets of New York after a whistle-stop visit to premiere breast cancer units in the USA. I wandered past the advert to 'The Lion King' (proudly African) and thought about the circle of breast cancer management seen in the last half-century and how this has affected women in SA diagnosed with the disease.

Fifty years ago, women's movements and clinicians started promoting certain aspects of breast health that steadily gained momentum throughout the world. Now it would seem that we have come full circle.

The first circle: Breast cancer screening

This is an emotive topic that has circled from no screening at all, to studies showing poor value and lack of success in self breast examination and clinical breast examination, to worldwide acceptance of screening mammography in women 40 years old and older. The November 2012 *NEJM* review[1] created a stir, as well as many heated debates, resulting in a move back to self breast examination due to a perceived lack of success in screening mammography in actually altering breast cancer mortality.

Maybe in a country like ours that cannot afford effective screening, we can lead the way with a reasonably balanced approach, awareness and teaching around breast examination (particularly as 60% of cancers here are diagnosed at sizes over 3 cm), more use of ultrasound-guided core biopsy diagnosis, and selective use of digital mammography and magnetic resonance imaging (MRI).

SA still gets a large zero and not a circle for the lack of acceptance of radiological-guided core biopsies for breast cancer, and the significant overuse of surgical biopsy diagnoses and clinician-directed pressure into urgent and 'emergency mastectomy' followed by adjuvant treatment.

The second circle: The move from the ablative mastectomies of the 1960s to breast conserving surgery and radiation therapy

The National Surgical Adjuvant Breast and Bowel Project (NSABP) trials by Fisher *et al.*,[2] showing equal survival outcomes with breast conserving surgery v. mastectomy, paved the way for the breast conservation era. Initial problems with large excisions, resulting in poor aesthetics, drove the migration towards pushing the aesthetics boundaries with the use of a variety of oncoplastic techniques – breast reduction reconstructions, local parenchymal flaps, larger autologous flaps – to the acceptance of closer margins to larger tumour size excision ratios and now back to the current trend, according to the Surveillance, Epidemiology and End Results (SEER) database of mastectomy (including 'prophylactic' risk reduction mastectomy),[3] only now with prosthetic reconstruction and nipple saving techniques (Barbie breasts at all costs!).

A full circle: With many new questions

Why are women now electing to remove breasts – both affected and essentially normal breasts? Is the answer as simple as our ability to reconstruct equal 'Barbie breasts' or is it more complex? Do repeated mammograms and call-backs and core biopsies, or over-diagnosing of potential pathology on MRI scans, and clinician-driven suggestions play a role in the type of breast cancer surgery offered?

And does the SA that now offers many good multidisciplinary units stand divided once again with the line firmly drawn between those clinicians who insist on breast conservation and those who don't.

Possibly the rainbow nation colours should shine and, as there are many different colours, so there are many different options, and in the proud month of August we should realise that as long as safe cancer rules apply, women should have some say as to how their feminine parts are treated.

The circle of change has rolled from surgery being the only real treatment of breast cancer, to the understanding of the biology of cancer, from the Halstedian concepts of breast cancer spread, to understanding the systemic nature of the disease, and the systemic treatment of the disease and the genetic profiling of cancers.

We have circled from the early 1970s understanding of the value of tamoxifen (a not-so-simple selective oestrogen receptor modulator) and other endocrine therapy, to the use of systemic chemotherapy for almost all invasive tumours over 10 mm in size. We now offer genetic profiling of cancers, resulting in less chemotherapy and more individualised treatment plans.

Possibly the biggest modern circle is the understanding of the whole – the concept that any break in a chain results in a suboptimal outcome.

Today, breast cancer management throughout the world, and in many centres in SA, has lead the way with the concept of multidisciplinary care, with many specialists participating in a combined approach to ensure better patient care. Doctors from radiology, pathology, oncology, surgery, and allied specialists (psychology, nursing) communicate and take time to ensure best patient care – with the circle or wheel being the patient who can move on from a devastating diagnosis – and drive the process to a united approach that ensures holistic patient care. Perhaps we can hold our next meeting at Pride Rock.[4]

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4. http://www.mylionking.com/wiki/Pride_Rock (accessed 5 July 2013).

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