More Women Opting To Remove Both Breasts

Surgeons conducting the largest study yet of women who have cancer in one breast but have both removed have found that this option has grown rapidly despite a lack of evidence that it improves long-term life expectancy. Their findings were recently reported in a study of almost 1.2 million women whose cases are documented in the National Cancer Data Base (NCDB) of the American College of Surgeons (ACS). The study was published in the October issue of *Annals of Surgical Oncology.*

Results defined patterns in the use of the surgical procedure to remove the noncancerous companion breast during mastectomy for the primary cancerous breast, a procedure called contralateral prophylactic mastectomy, or CPM. The researchers did not look at survival after the procedure, but study authors said they would investigate survival in the future once data has become mature.

“We have described a dramatic increase in the use of contralateral prophylactic mastectomy over the last 10 years,” said senior study author David P. Winchester, MD, FACS, Medical Director of Cancer Programs at the American College of Surgeons, a surgeon at NorthShore University HealthSystem, Evanston, IL, and faculty member at the University of Chicago. “The incidence increased from a fraction of a percentage, 0.4 percent in 1998, to 4.7 percent in 2007.”

Researchers noted the greatest increase among white women younger than 40; more than 10.5 percent of whom with single-breast cancer underwent CPM. Women with private insurance were more than twice as likely to have contralateral mastectomy as uninsured women and Medicare beneficiaries. Likewise, women in the highest income zip codes were twice as likely to have CPM as women in lower income areas, the researchers reported.

Results showed that regionally, women in the Midwest had the highest rates of CPM, 6.4 percent in 2006-2007, followed by the South with 5.6 percent. The lowest rates were in the Northeast, 3.3 percent. Surgical procedure rates also varied depending on tumor size and type. “In general, the trend showed the more early stage a cancer, the higher the rate for contralateral mastectomy as compared with a later stage cancer,” said lead author Katharine Yao, MD, FACS, director of the breast program at NorthShore University HealthSystem, Evanston, IL, and faculty member at the University of Chicago. The smallest noninvasive tumors, or *in situ* tumors, had a CPM rate of six percent compared with the largest tumors, known as T4, at a rate of 2.4 percent. As for tumor type, *in situ* cancer of the breast and lobular carcinomas had a CPM rate of 5.6 percent while ductal cancers had a CPM rate of 3.9 percent.

The study also looked at the type of hospital where the operations were performed. “Patients seen at a teaching or academic medical center were 2.5 times more likely

to have a contralateral prophylactic mastectomy when compared with a small community hospital," Dr. Yao said. "Treatment with contralateral mastectomy was also more frequent in high-volume centers—almost three times as likely as opposed to low-volume centers."

Despite the paucity of published evidence that CPM prolongs life, Dr. Winchester said CPM makes sense for many women. He attributed its growth in utilization to greater awareness among women.

"There is a high level of awareness and anxiety about breast cancer in the United States," he said. "Younger women, in particular, who have a very long life expectancy with a very long risk period—particularly those with a family history and knowing that they already have breast cancer—are making these decisions." Another factor influencing this trend may be a greater reliance on genetic testing for breast cancer, he said.

However, the National Cancer Data Base data the investigators used did not track family history or genetic testing. "But even without a genetic mutation and with or without a family history, the number one risk factor for breast cancer is a personal history of breast cancer," Dr. Winchester said. With early stage noninvasive cancer of the mammary lobes and a family history, the risk of cancer can increase two percent a year. In a 40-year-old woman with a 40-year life expectancy, "you're looking at a very, very high risk," Dr. Winchester explained.

Another consideration for double mastectomy for single-breast cancer is a woman's desire for breast symmetry and reconstruction. "It's usually necessary to operate on the companion breast to make a match when the cancer side undergoes reconstruction," Dr. Winchester said. "Very often this approach makes cosmetic sense."

The study underscores a need for thorough discussions between the surgeon and patient with breast cancer. "Contralateral mastectomy may make a lot of sense in some cases, but it needs to be an objective, evidence-based discussion between the surgeon, patient, and family," Dr. Winchester said.

"If a woman with locally advanced breast cancer wants the opposite breast removed, the surgeon needs to carefully counsel that patient that her major risk is the breast cancer, not her opposite breast," he said. Taking the time for removal of the opposite breast could delay post-operative chemotherapy or other treatment, "in which case I would encourage the patient not to have the contralateral prophylactic mastectomy," he added. However, stage 1 or 2 cancer poses a different challenge. "Then the comparative risk would justify doing that CPM," Dr. Winchester said.

In addition to Drs. Yao and Winchester, the research team also included David J. Winchester, MD, FACS, NorthShore University Medical System, and Andrew K. Stewart, MA, American College of Surgeons.

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