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Information Please

BY CHARLOTTE HUFF

Why aren't more women having breast reconstruction?

Sue Hadden flatly rejected her physician's suggestion that she consult with a plastic surgeon prior to her mastectomy. "My reaction was, 'I want [my breast] off. I don't want any extra surgery. I just want to get on with my life,'" Hadden says, recalling those early days after her 2-centimeter stage 1 tumor was found. "I don't think of myself as very vain. I think of plastic surgery as something you do when you're vain."

But her oncology surgeon persisted, scheduling an appointment for Hadden. Over the next couple of weeks, the 50-year-old pediatric nurse from Michigan reviewed studies on surgical complications and talked to numerous breast cancer survivors—both those who had opted for and against reconstruction. "I went around and around," she says. "I really, really struggled with this decision."

In 2005, Hadden underwent a mastectomy of her left breast, along with immediate reconstruction. More than two years later, she describes the decision as "the right one" for her.

Among mastectomy patients, though, Hadden falls into a distinct minority. Nearly 51,200 women underwent a mastectomy between 1998 and 2002. But fewer than one in five eligible women, or 16.5 percent, chose immediate reconstruction, initiating the procedure within four months, according to data published in 2006 in the *Journal of the American Medical Association*. The rates also didn't change significantly from year to year, despite the passage of the Women's Health and Cancer Rights Act of 1998. The federal law requires insurers, including group plans and individual plans, that cover mastectomy to also pay for reconstruction. State laws may provide additional protections.

The current reconstruction rate preoccupies Amy Alderman, MD, author of the *JAMA* analysis and several other recent studies on access to breast reconstruction. "Is it because not many women want it?" she asks. "Or, is there an access barrier?" Dr. Alderman, an assistant professor of plastic surgery at the University of Michigan Medical School, performed Hadden's reconstruction.

Access, if it is an issue, is likely not the only reason relatively few women select reconstruction, according to breast cancer clinicians interviewed. Women who are wrestling with complex treatment decisions may not have the energy to also sift through and select a reconstruction procedure. They may be reluctant to undergo the risks of additional surgery, or the scarring that can be involved. They may not place a particularly high priority on regaining cleavage, or they may worry about

cost, despite broader insurance coverage requirements.

☒ I consider reconstruction part of [the woman's] psychological treatment for this disease. She was born with two breasts. She still can have two breasts. ☒

—Lillie Shockney, RN

Still, Lillie Shockney, RN, administrative director of the Johns Hopkins Avon Foundation Breast Center in Baltimore, wonders if too many women dismiss reconstruction without measured consideration. “I commonly hear women say, ‘I don’t want to ask for too much. I just want to live.’ Like they will jinx themselves,” says Shockney, a breast cancer survivor who chose reconstruction 10 years after her breast cancer surgery. “I tell women to look at the long view. How do you want to look and feel a year from now?”

“I consider reconstruction part of [the woman’s] psychological treatment for this disease. She was born with two breasts. She still can have two breasts,” says Shockney.

Access and Referrals

Dr. Alderman’s JAMA analysis, based on National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) data, also revealed other trends, such as disparities among ethnic groups. In 2002, the most recent data analyzed, the immediate reconstruction rate was 11 percent for Hispanic women and 8.5 percent for Asian women compared with 17.7 percent for white women and 18.6 percent for African- American women, according to the study’s results. SEER doesn’t track reconstruction data beyond four months after mastectomy, Dr. Alderman says.

Neither do many surgeons routinely refer breast cancer patients for a plastic surgery consult prior to mastectomy, according to another study of Dr. Alderman’s, published earlier this year in the journal *Cancer*. Only 24 percent of 342 general surgeons surveyed in Detroit and Los Angeles referred more than 75 percent of their patients prior to surgery. (High referral surgeons were more likely to be female and handle a large number of breast surgery cases, among other factors.) Nearly half—44 percent—referred fewer than 25 percent to a plastic surgeon.

Overall, the general surgeons posed a variety of explanations for why they thought women might not be interested: reconstruction was not important (57 percent); reconstruction would take too long (39 percent); or cost of the procedure concerned them (46 percent). “I don’t think these physicians are bad people,” Dr. Alderman says. But they may not be working in a setting, such as an academic medical center or a multi-disciplinary cancer program, where referrals are easily accomplished, she says.

Reconstruction can be labor intensive, with numerous consults outside of the operating room, making it less financially attractive for some plastic surgeons, says Gail Lebovic, MD, who specializes in oncoplastic surgery, a new subspecialty that combines surgical oncology with aesthetic and reconstructive surgery. Dr. Lebovic, director of women's services at The Cooper Clinic in Dallas, says some of her patients travel from as far away as Arkansas because of access difficulties.

"The medical economics has driven the plastic surgeons away from wanting to do it (reconstruction), which has left the patients kind of high and dry," she says. Indeed, insurance reimbursement for breast reconstruction is much less than other elective plastic surgery procedures.

Data from the American Society of Plastic Surgeons reveal a substantial decline in breast reconstructions, down 31 percent between 2000 and 2006, from an estimated 80,908 to 56,176 last year. "We're actually not sure why," says Debra Ann Reilly, MD, a spokeswoman for ASPS and an associate professor of plastic and reconstructive surgery at the University of Nebraska Medical Center.

But Dr. Reilly takes a different view from Dr. Lebovic, saying the issue is not a shortage of willing plastic surgeons, but rather that other physicians don't necessarily refer the cases. Also, radiation is being used more frequently, which can complicate reconstruction (see sidebar). Once reconstruction is delayed by months of radiation and other treatment, some women may reject the idea of further surgery, Dr. Reilly says. "It gets overwhelming. You want your life back."

The Question of Timing

As more women get radiation to treat even early-stage breast cancers, the reconstruction process has become more complex, says Steven Kronowitz, MD, associate professor in the department of plastic surgery at Houston's M.D. Anderson Cancer Center. Women might not know for a week after mastectomy whether they need radiation, depending upon the final analysis of breast tissue and lymph nodes, he says.

Radiation, when performed after reconstruction, may damage the tissue of the reconstructed breast, increasing the need for a subsequent surgical repair, Dr. Kronowitz says. Also, reconstruction may complicate effective radiation delivery, according to a study published last year in the *International Journal of Radiation Oncology*. The research, involving 218 women, found that half of those who underwent immediate reconstruction had radiation treatment issues emerge, such as difficulty in adequately treating some lymph nodes, compared with 7 percent of the controls.

To preserve both treatment and cosmetic options, Dr. Kronowitz performs a procedure called delayedimmediate breast reconstruction. At the time of the mastectomy, a saline-filled tissue expander is placed underneath the breast skin to retain the breast's shape and much of the woman's own skin for later reconstruction.

If radiation is not required, the mastectomy can be completed within a few weeks. If subsequent radiation is recommended, the implants are deflated for the procedure itself to reduce any possibility of interference, and then slowly inflated

later in preparation for eventual reconstruction, Dr. Kronowitz says.

The two-stage approach also can be helpful for other patients, such as women who need to stop smoking before they undergo reconstruction, Dr. Reilly says. Smoking leads to constriction of the blood vessels, making it more difficult to maintain an adequate blood supply to the reconstructed breast.

Emotional Underpinnings

Of course, not everyone desires reconstruction. Michelle Churches, a nursing colleague of Hadden's, was diagnosed with stage 2 breast cancer at about the same time. After three positive sentinel lymph nodes were identified, Churches hit treatment on all cylinders with a mastectomy, chemotherapy, and radiation.

She had initially considered reconstruction, but decided she didn't want yet more surgery. "I had a goal," says Churches, now 44. "I wanted to get this [treatment] done before the end of the year. Plus, I'm comfortable with my body. I've been married 25 years to the same guy and I have three kids."

Shockney, who was first diagnosed with breast cancer in 1992, didn't initially choose reconstruction because of a mixed bag of concerns, including a personal history of serious anesthesia complications. Plus, she wasn't sold on the various reconstruction options available at the time. In the years since, a tissue-flap procedure called the DIEP (deep inferior epigastric artery perforator) flap was developed, which didn't involve the removal of abdominal muscle, making reconstruction more attractive, she says.

After some soul searching, Shockney underwent the surgery in 2002 shortly before turning 50. Women, she says, "underestimate how good [reconstruction] is for their psychological well-being. It's even better for me than I'd ever anticipated it being."

How many women, like Shockney, get reconstruction months or even years later? To answer that question, Dr. Alderman is analyzing data from women in Detroit and Los Angeles to determine if they have regrets about having reconstruction or not having it, and, if so, have they returned to the operating room?

Hadden's surgical choice, by her own description, didn't turn out to be a cake walk. Her stage 1 breast cancer unexpectedly required radiation after her pathology report raised concerns that a few malignant cells might remain near the chest wall. About a year after her mastectomy, Hadden underwent another surgery to remove radiation-damaged tissue, along with surgery to match the opposite breast.

These days, the athletic nurse jokes that she's finally achieved her long-sought B cup. And she doesn't regret having reconstruction immediately. "I don't know if I would have gone back," she says. "You just don't want to interrupt your life to have surgery."