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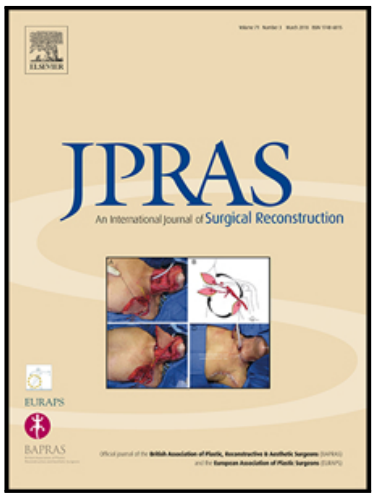

Reduction mammaplasty technique. The core and the master key of oncoplastic breast surgery.

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Reduction mammaplasty technique. The core and the master key of oncoplastic breast surgery.

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Dear Sir,

In 2011, I presented an idea for the debate without any success. It was published as a controversial question, incorporating the surgical treatment of symptomatic macromastia in a Breast Cancer Unit: could this be a useful management policy?[1]. Several years after seeing the development of oncoplastic surgery, I think it deserves to be presented again.

Nowadays, therapeutic mammaplasty or the use of a reduction mammoplasty technique (RM) to treat conservatively a breast cancer with oncoplastic surgery (tumor adaptive reduction mammaplasty) is considered a current standard procedure [2], and is clearly the most frequent [3]. This is because RM is a truly versatile technique that allows the surgeon to remove a tumor located in any quadrant of the breast with only one of the following two conditions: moderate or large breast size or enough breast inferior pole to remodel (ptosis). In addition, the technique is safe and effective oncologically, with an acceptable morbidity and a good cosmetic result and a high patient satisfaction score [4].

In saying this, it is clear that RM is a useful and indispensable tool for a breast surgeon who wants to perform modern breast surgery. The surgeon who handles RM is able to face oncoplastic breast conservation surgery and symmetrization of the contralateral breast in the context of conservative treatment or in the process of postmastectomy breast reconstruction.

The most valuable property of RM is that it combines many surgical details or steps that are the surgical basis of the rest of most oncoplastic techniques. In my opinion, the way is easier when the surgeon tries to learn this first than if they hardly advance from the inferior level techniques stopping when they reach the RM and considering them as a limit or a border.

Another point, perhaps the most critical, is that there is a lack of training with evident barriers to access to learning. A survey conducted by the Oncoplastic Surgery Committee of the American Society of Breast Surgeons with 708 respondents (representing 26% of active practice membership) showed that a minority of respondents reported having breast reductions / mammoplasty performed independently (19%) or contralateral symmetry (10%) and interest in oncoplastic surgery among surgeons it is significant, but there are barriers to incorporating these surgical techniques in a breast surgeon practice [5].

About symptomatic macromastia, the following statement is universal and real, surgeons have an effective and efficient treatment consisting of RM that is administered under strict, inadequate and inequitable criteria, as the term "postal code lottery" refers to [6].

At that time, I proposed a naive idea as one of the possible solutions, why not incorporate the treatment of macromastia in breast units? This policy offers two advantages: increasing the insufficient supply for patients with large breasts suffering from symptomatic

macromastia and enabling the training in reduction mammoplasty techniques for breast surgeons.

I said that it was naive because I know that breast cancer is a border issue between specialties and specialists, for example, in Europe, Gynaecology, General Surgery and Plastic Surgery share this field. I think we are all aware that nobody can now, nor in the future we will treat breast cancer exclusively, so cooperation should be the way to treat, teach and learn.

Our experience similar to that of others confirms that this management policy is very useful and viable.

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