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EDITORIAL – BREAST ONCOLOGY

Commentary on the Consensus Statement of the American Society of Breast Surgeons on Contralateral Prophylactic Mastectomy

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ABSTRACT The increasing rate of contralateral prophylactic mastectomy (CPM) led the American Society of Breast Surgeons (ASBrS) to issue an evidence-based consensus statement on CPM, as well as a discussion guide that health care providers can use to facilitate shared decision making with patients considering CPM for unilateral breast cancer. This article suggests several ways to improve the discussion guide by eliciting patient values and preferences and by providing more current, detailed, and balanced information about the potential risks and benefits of CPM.

We commend the American Society of Breast Surgeons (ASBrS) for addressing the complex issue of contralateral prophylactic mastectomy (CPM) with a thorough review of the data and a well-balanced consensus statement.[1] We are concerned, however, that the discussion guide for shared decision making does not achieve the authors' stated goal of considering "the patient's preferences and values and an informed discussion of the risks and benefits of CPM."[2] None of the talking points guide the provider in eliciting a patient's preferences and values. Also, only one talking point includes a potential benefit of CPM (that women who undergo CPM will not need mammograms or routine breast imaging for cancer screening after surgery), whereas the remaining talking points focus on the harms and limitations. Overall, the selection and framing of many of the discussion points are intended to discourage CPM (a stated goal) rather than provide a neutral overview of the individualized potential risks and benefits of CPM.

Shared decision making has been defined as a collaborative process that allows patients and their health care providers to make well-informed decisions together with the goal of achieving outcomes that matter most to the patient.[3] Well-designed patient decision aids have been shown to enhance patient knowledge and improve the quality of these decisions, including decisions about breast cancer surgery.[4,5] A systematic Cochrane Review found that compared with standard care, patient decision aids can enhance patient understanding, including substantial improvement of perceived personal risk, and lead to a better match between values and choices, with no or minimal effect on anxiety, depression, regret, consultation length, or health-related quality of life.[6]

The International Patient Decision Aids Standards (IPDAS) Collaboration has established a framework for improving the content, development, implementation, and evaluation of patient decision aids, including checklists, tools for evaluation, and minimal standards.[7,8] Their framework calls for a systematic development process using up-to-date evidence, balancing presentation of information and options, clarifying values and preferences, and measuring effectiveness.

We encourage the ASBrS to facilitate shared decision making by engaging a multidisciplinary group of experts and applying the IPDAS framework to strengthen and evaluate their discussion guide. We also suggest specific ways to improve several points in the ASBrS discussion guide, presented in Table 1. For example, it would be helpful to include information about absolute risk[9] for surgical complications and for contralateral breast cancer after CPM, as well as more recent data on quality of life after CPM.[10–12] In addition, women should be provided with information about breast reconstruction options[13] and

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TABLE 1 Suggested modifications to the ASBrS discussion guide for contralateral prophylactic mastectomy (CPM)

Discussion point[2]	Suggested addition or modification
"For most women, the estimated risk of cancer in the opposite breast is 2–6 % over the next 10 years. This means you have a 94–98 % chance of not getting cancer in your opposite breast over the next 10 years or more."	It would be helpful to provide an estimate of lifetime risk for contralateral breast cancer and how that risk may vary based on patient and tumor characteristics as well as the treatment received for the index cancer.[1] It's not clear why this statement concludes with "10 years or more."
"CPM is not 100 % protective against cancer forming in your other breast."	A patient would be better informed by adding the following information: CPM reduces the relative risk of cancer in the contralateral breast by 90 % to 95 %; the absolute (lifetime) risk of developing cancer on that side is less than 1.5 %.[1]
"The risk of surgical complications at the surgical site (such as bleeding, infection, healing complications, and chronic pain) is approximately twice as high when CPM is performed."	Information about the absolute risk for major and minor complications would be helpful.[9] It should also be pointed out that complication rates vary with patient factors (e.g., comorbid medical conditions).[1]
"CPM with reconstruction will result in an increased number of operations."	Timing of reconstruction depends on a number of factors, but in some cases, it may be performed at the same time as the mastectomy. Consultation with a reconstructive surgeon can provide a detailed discussion about what each reconstructive procedure involves, recovery time, the need for additional surgeries, and the potential benefits and risks associated with the procedures.[1]
"CPM may be associated with negative impact on physical, emotional, and sexual well-being. Approximately 10 % of women regret their decision to undergo CPM."	This estimate is derived from patients treated decades ago.[2] Some studies found lower rates of regret,[2] and studies of more contemporary patients using the BREAST-Q PRO instrument[14] found that CPM with reconstruction was associated with equal or better breast satisfaction and psychosocial, physical, and sexual well-being.[10–12]

should be encouraged to consult with a reconstructive surgeon[1] to ensure that they are better informed about the potential benefits and risks of reconstructive procedures before making a final decision. Recent studies that collected patient-reported outcomes (PROs) using a well-validated, breast surgery-specific instrument (BREAST-Q)[14] demonstrate that breast reconstruction can improve women's satisfaction as well as their psychosocial, physical, and sexual well-being after mastectomy.[15–17]

In summary, we agree with the consensus statement that CPM should not be routinely performed in the absence of evidence for a survival benefit. But mortality is not the only oncologic outcome that concerns women.[18,19] Imaging surveillance has limitations and can be very stressful. Furthermore, a diagnosis of contralateral breast cancer may trigger a new round of treatment with all the associated short- and long-term effects on health and quality of life, including renewed anxiety about additional recurrences. A pilot test of one decision aid for CPM showed significantly increased patient knowledge but not a reduction in the rate of CPM.[20] For some women (e.g., a young healthy woman with early-stage cancer who has experienced significant difficulties with breast cancer screening due to dense tissue or other factors), the risk-benefit tradeoff for CPM may align well with their personal goals, values, and preferences. When making life-altering treatment decisions, those preferences should factor into a well-informed decision-making process.[21]

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