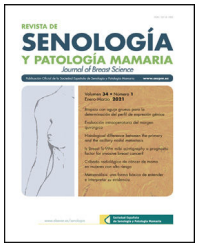
Revista de Senología y Patología Mamaria 34 (2021) 122–124

Sociedad Española de Senología y Patología Mamaria

REVISTA DE SENOLOGÍA Y PATOLOGÍA MAMARIA
Journal of Breast Science
www.elsevier.es/senologia



CARTAS AL DIRECTOR

Micropigmentación de pezón y areola tras mastectomía

Micropigmentation of the nipple and areola after mastectomy

Sr. Director:

Nos parece muy interesante el artículo publicado por Martínez-Pizarro sobre la micropigmentación de pezón y aréola para la reconstrucción tras mastectomía[1]. Pensamos que es un gran acierto dedicarle un artículo a este tema en una revista científica pues, en general, se tiene poco conocimiento debido a que, en muchas ocasiones, estas técnicas son realizadas por personal ajeno a la sanidad. No obstante, en los últimos años algunos profesionales sanitarios nos hemos interesado en ello y, como apunta la autora, se han podido integrar en diferentes centros como parte de la reconstrucción mamaria después de un cáncer. Sin embargo, con respecto a la experiencia de la autora nos gustaría hacer algunas matizaciones que creemos complementan sus datos. Según nuestra experiencia, la duración de la micropigmentación podría ser algo menor a la descrita en su trabajo. Como muy bien se apunta al principio del artículo, en el caso de la micropigmentación la implantación de los pigmentos se realiza en la capa superficial de la piel y, más específicamente, en la capa basal de la epidermis. Debido al recambio fisiológico de la propia epidermis, se realiza también una «descamación» de los pigmentos en ella insertados, reduciéndose así el tiempo de duración. De este modo, según nuestra propia experiencia, la duración del pigmento suele ser menor a lo deseado, siendo de alrededor de 2 años. Es entonces cuando suele ser necesario hacer el repaso.

Creemos que todavía queda mucho camino por recorrer para que el tratamiento integral del cáncer de mama sea una realidad en todos los centros. No obstante, experiencias como la que la autora nos presenta en el Hospital San Cecilio de Granada abren las puertas para seguir mejorando en la atención a las pacientes con cáncer de mama.

Véase contenido relacionado en DOI:
https://doi.org/10.1016/j.senol.2020.06.009

Bibliografía

1. Martínez-Pizarro S. Micropigmentación de pezón y areola tras mastectomía. Rev Senol Patol Mamar. 2020;33:168–9.

Diana María López Pareja[a,*] y Laura Simón Monterde[b]

[a] *Medicina Familiar y Comunitaria, MIR Hospital General Universitario de Castellón, Máster en Medicina Estética, Universidad a Distancia de Madrid, Collado Villalba, Madrid, España*

[b] *Medicina Familiar y Comunitaria, MIR Hospital General Universitario de Castellón, Máster en Medicina Estética, Rey Juan Carlos, Móstoles, Madrid, España*

* Autor para correspondencia.
Correo electrónico: dilopepa2@gmail.com
(D.M. López Pareja).

https://doi.org/10.1016/j.senol.2020.11.001
0214-1582/

Patient-reported outcomes in breast conserving treatment. Information given by breast surgeon. What to improve

Resultados comunicados por las pacientes en el tratamiento conservador del cáncer de mama. Información dada por el cirujano. Qué mejorar

Dear Editor:

Patient-reported outcomes (PRO) offers very important information on how patients experience their disease and treatment. The BREAST-Q questionnaire, a PRO measure, which has been recommended in the management of the breast cancer,[1] is a validated, multidimensional questionnaire-based tool that assesses PRO measurements following breast surgery. It measures patient experience and quality of life using a hierarchy of questions exploring physical, psychological and sexual wellbeing, cosmetic appearance, and overall satisfaction, all of which are ranked by using a simple Likert scale. Finally, it offers several domains scoring from 0 to 100 (worst to best).[2]

The BREAST-Q questionnaire asks patients how satisfied or dissatisfied they were with the information received from the breast surgeon by using twelve questions which can be grouped depending on the election of the type of surgery (mastectomy versus breast conserving surgery), the possible

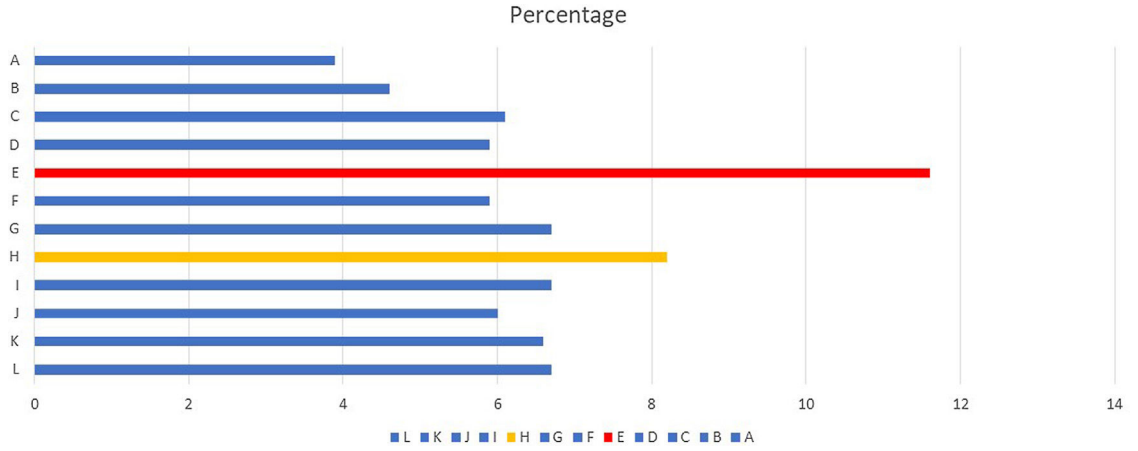


Figure 1 Percentage of patients who responded very or some what dissatified.

complications and postoperative course, consequences of positive lymph nodes and the alteration that can be expected after breast conserving treatment (BCT) (surgery plus radiotherapy).

Previously published experiences with the Breast Conserving Therapy of BREAST-Q, Module Postoperative Scales, showed the same observation. The satisfaction with the information given by the surgeon was scored around 20 points less than other domains, such as the satisfaction with the surgeon or the rest of health providers, medical team or office staff.[3–8]

One hundred and ninety-five women with primary early breast cancer who were treated with BCT at our Breast Unit in 2017 and 2018 were invited to participate after radiotherapy was completed. The study was approved by the Institutional Research Ethics Committee. All participants signed written informed consent and completed the BREAST-Q Version 2.0 Breast Conserving Therapy, Module Postoperative Scales, Spanish (ES) Version questionnaire in paper-and-pencil administration, which was then returned to our processing nurse.

List of queries:

a. The possible need for radiation depending on the surgery you undergo (mastectomy vs lumpectomy?)
b. The options you were given regarding the types of breast cancer surgery (mastectomy vs lumpectomy?)
c. How your survival would be the same with either type of surgery (mastectomy vs lumpectomy?)
d. Healing and recovery time
e. What your treatment plan would involve if the cancer is found in your lymph nodes
f. How much pain to expect during recovery
g. Possible complications?
h. How the chances that the cancer would come back would be the same with either type of surgery (mastectomy vs lumpectomy?)
i. What you could expect your breast to look like after lumpectomy surgery?
j. What the lumpectomy scars would look like?
k. What size you could expect your breast to be after lumpectomy surgery?
l. What shape you could expect your breast to be after lumpectomy surgery?

Patients can choose one of the following answers: very dissatisfied, somewhat dissatisfied, somewhat satisfied and very satisfied.

Clinical data were collected from hospital electronic patient records and responses for 'satisfaction with information-breast surgeon' – domain were transformed on a scale of 0–100 according to the BREAST-Q protocol, with a higher value representing a more favorable outcome. Patients who answered less than 50% of the questions on a scale were excluded from that specific scale.

A total 169 patients had BREAST-Q data available for analysis, 26 patients (13.3%) did not fill in the questionnaire for different reasons (some of them simply refused to do it, they did not have their glasses with them, etc.). The median and interquartile range of age, body mass index and time passed from date of surgery to BREAST-Q completion were 58.5 (12.10) years, 26 (6.42) kg/m^2 and 14 (11.75) months, respectively. Forty-nine patients (29%) were active smokers, 83 patients (49.1%) had comorbidities and 59 (34.9%) had a background of relatives with breast cancer. Concerning the type of surgery planned and carried out, 59 patients (34.9%) were treated using oncoplastic breast conserving techniques.

The satisfaction with information given by breast surgeon scored 63 (43) points over 100, median and interquartile range, this variable did have not normal distribution. None of the variables previously described showed a significant correlation with satisfaction with information score tested by Spearman and *U* Mann–Whitney tests. Fig. 1 demonstrates the percentage of patients who answered *very* or *somewhat dissatisfied* in each question.

Our patients scored the information given from us like as others studies[3–7]; the items that had the worst scored were those related to the consequences of metastasis in axillary lymph nodes and the risk of breast cancer recurrence. One explanation for this could be the fact that the information provided was deficient. In addition, patients usually consider these points very important and they can cause a great deal of concern.

The breast surgeon should be aware that information is very important and that it should be evaluated and improved. One way of attaining the last objective would be by giving structured information and checking it at the end of the visit to the surgeon's office to ensure that all points have been explained and discussed, especially those related to the role of axillary lymph nodes and the risk of breast cancer recurrence.

Bibliografía

1. Chen CM, Cano SJ, Klassen AF, King T, McCarthy C, Cordeiro PG, et al. Measuring quality of life in oncologic breast surgery: a systematic review of patient-reported outcomes measures. Breast J. 2010;16:587–97, http://dx.doi.org/10.1111/j.1524-4741.2010.00983x.
2. Pusic A, Klassen AF, Scott AM, Klot JA, Cordeiro PG, Cano SJ. Development of a new patient-reported outcome measure for breast surgery: the Breast-Q. Plast Reconstr Surg. 2009;14:345–53.
3. O'Connell RL, DiMicco R, Khabra K, O'Flynn EA, deSouza N, Roche N, et al. Initial experience of the BREAST-Q breast-conserving therapy module. Breast Cancer Res Treat. 2016;160:79–89.
4. Fuzesi S, Cano SJ, Klassen AF, Atisha D, Pusic A. Validation of electronic version of the BREAST-Q in the army of women study. Breast. 2017;33:44–9, http://dx.doi.org/10.1016/j.breast.2017.02.015.
5. Di Micco R, O'Connell RL, Barry PA, Roche N, MacNeill FA, Rusby JE. Standard wide local excision or bilateral reduction mammoplasty in large-breasted women with small tumours: surgical and patient-reported outcomes. Eur J Surg Oncol. 2017;43:636–41, http://dx.doi.org/10.1016/j.ejso.2016.10.02.
6. Vrowe SO, Somogyi RB, Snell L, Mc Millan C, Vesprini D, Lipa JE. Patient-reported outcomes following breast conservation therapy and barriers to referral for partial breast reconstruction. Plast Reconstr Surg. 2018;141:1–9, http://dx.doi.org/10.1097/PRS. 0000000000003914.
7. Gardfjell A, Dahlbäck C, Ahsberg K. Patient satisfaction after unilateral oncoplastic volume displacement surgery for breast cancer, evaluated with the Breast-QTM. WJSO. 2019;17:96–109, http://dx.doi.org/10.1186/s12957-019-1640-6.
8. Hernanz F, Jimeno J, Muñoz P, Diaz S. Patient-reported outcomes following breast conserving treatment using Breast-Q questionnaire. Eur J Plast Surg. 2019, http://dx.doi.org/10.1007/s00238-019-01589-9.

Fernando Hernanz*, Lucía Paz, Jaime Jimeno, Erik Tolaretxipi, Ana Lozano, Pedro Muñoz

Breast Unit, Hospital Universitario Marqués de Valdecilla, Santander, Spain

* Corresponding author.
E-mail address: cgdhff@humv.es (F. Hernanz).

https://doi.org/10.1016/j.senol.2020.04.003