

SPECIAL ISSUES IN BREAST CANCER

EDITORIAL

Verba volant, scripta manent*

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Some great men have left their mark on the practice and teaching of medicine and surgery in Lebanon in the last half-century. They had the difficult task of teaching and initiating their students to the art of scientific care of the patient [1-3].

Those physicians had a great passion for their work, as each patient presented a new challenge for them, necessitating a new personalized approach, a new way of sharing their experience with the younger generation [4-13]. Those doctors laid down the foundation for the development of Lebanese medicine. Their approach to teaching and to patient care attracted a group of followers, even distant ones, inducing some “rebels” to follow in their footsteps. Those people were at the core of basing Lebanese medicine on evidence, scientific work and the quest for truth [14].

Those eminent doctors have worked in Lebanon with virtually no resources, yet they were able to give, teach and care in an artful way and with unparalleled professionalism.

It was during my residency that I became a student of one of those great teachers, the likes of whom cannot be easily found nowadays. He was passionate about breast surgery, practicing sometimes under adverse conditions, but doing everything properly without compromising the optimal outcome of the surgical procedure to be done. During my internship, I saw him at work. Each patient was a lesson for us, even an entire course. The seriousness and honesty with which he operated have remained etched in the minds of all those who had him as a master. Here is a great opportunity to have this illustrious man share with us his wide knowledge and his passion to explore all the novelties in his field. We are honored to have Professor Antoine Ghossain write in this issue about the history of breast surgery, with references to what was actually practiced in Lebanon.

In fact, breast cancer in Lebanon has become a social

problem. The number of cancers per year is constantly on the rise [15].

The evolution of knowledge in breast cancer is so exponential that subspecialists are needed in that field.

Multidisciplinary teams are essential to enable proper decisions regarding patient management. As you will discover in this issue, the understanding of certain phenomena in breast diseases is essential in order to propose adequate treatments after percutaneous biopsy or surgery. Histology is the cornerstone of this understanding. The pathologist will have the difficult task of describing the lesion and putting a label on what he sees. The problem is no more to say that this is a cancer or not as it was in 1965 but to give more details on the margins of tumor resection, on the histological type, on the receptors... in addition to describing lesions still little known, like the ones described by Nasser et al. [16-17] and to fit them in a category. But to do this will first require consulting the radiologist who will guide the biopsy. The BI-RADS terminology now in wide use is well described in the paper of Kanso et al. [18], with all its advantages and limits.

Introducing breast MRI has added a powerful tool to detect and better define the limits of breast lesions, but has complicated our management of the patient with some difficulties in avoiding false positives.

It is merely stating the obvious to say that the breast is part of the identity of the woman. On this basis, attention to the esthetics of the breast is essential to the care of breast cancer [19]. Indeed, the purpose of neoadjuvant chemotherapy before reconstructive and oncoplastic breast surgery and skin-conserving procedures, is to preserve the esthetics of the breast. As Professor Ghossain [20] showed in his paper, it is no longer acceptable to leave out or ignore the body image of women, while relying on the fact that the breast is not a vital organ. The removal of the breast with the amputation that follows is as deleterious as a breast disfigured by an unplanned surgery. For example, incisions in the upper inner quadrant are unacceptable. Nothing is more disgraceful than a scar for a woman's cleavage! It goes without saying that many unsightly incisions are encountered because the breast is an accessible organ and tumor access easy. The surgeon is often the first to deal with this problem. In most cases the scalpel should initiate treatment. Surgical management, if a little careless, may have far-reaching consequences, given that the surgical outcome is a prognostic factor. Non oncologic or ill-suited surgery will harm not only the esthetics of the breast but will also affect the patient's survival.

The management of breast cancer should therefore be codified and adapted to new technologies and recom-

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mentations. We must always think about the post-treatment psychology of the woman before deciding on the first incision.

In the middle of the last century, George Crile Jr. [21-22] shocked his contemporaries by stating that Halsted-type ultra radical surgery of breast cancer was outdated. He advocated local treatment or simple mastectomy or quadrantectomy without axillary dissection; he also considered that the regional lymph nodes were necessary for antitumor immunity. That was considered “the heresy of heresies” by the puritans of that era. More than fifty years later, technological advances and the use of sentinel lymph node procedures have demonstrated the scientific basis for his theories. With the sentinel lymph node procedure, over 80 percent of axillary dissections can be avoided in T1 tumors and 40 percent in T2 tumors without affecting the chances of the patients’ survival. Axillary recurrences are never fatal and their surgical dissection is feasible but tedious, resetting the treatment counters to zero. On the other hand, immunologists working in the field of breast cancer vaccination consider the axillary lymph node dissection a major immunological nonsense. The sentinel lymph node would be an excellent alternative.

From now onwards, we must think of the future of the patient and the means to consolidate the treatment. Hormone therapy has long been used for this purpose. However, a new vision with the various hazards is examined by Chahine et al. [23].

In summary, we can talk therapies and modern management but all our efforts will be in vain if patients do not present for screening, and especially if a good policy does not emerge based on solid recommendations [15]. The spoken word may be forgotten, but written ones persist!

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