BACKGROUND

Although 97–99% of breast cancers occur in only one breast, some women choose also to remove the healthy breast—a contralateral prophylactic mastectomy (CPM).

Majority of women with unilateral breast cancer (BC) do not have BRCA mutations and their risk of local and contralateral recurrence is extremely low with limited recurrences and advances in adjuvant management.2

We are seeing more women with unilateral breast cancer opt for bilateral mastectomy or more radical mastectomies3.

Predictors of CPM may include fear of a subsequent breast cancer diagnosis, desire for cosmetic symmetry, family history of breast cancer, and genetic susceptibility related to BRCA1 and BRCA2 genes.4

Increasing use of CPM is not always associated with increased recognition of patients at high risk for CBC5.

As the use of MRI increased from 10% in 2003 to 23% in 2006, patients with MRI were more likely to undergo mastectomy than those without MRI (54% vs 36%).6

Regional and national cohorts suggest after an initial decline in late 90’s a shift in mid-2000’s toward increasing proportion of women choosing mastectomy over BCT, in patients eligible for BCS7,8.

In a recent AHRQ study among women undergoing treatment for early-stage breast cancer, the percentage of those having CPM increased more than fivefold between 1998 and 2011 (from 1.9 to 11.2 percent).9 No clear evidence for a survival benefit is seen in patient subgroups, although 97–99% of breast cancers occur in only one breast, and during most recent years, there was a shift in mid-2000’s toward increasing proportion of women choosing mastectomy over BCT, in patients eligible for BCS7,8.

RESULTS

Among 533 patients, 510 (82%) had early stage (0-3) resectable BC. Among these, 48% (246/510) had either MRM (215/510) or BM (37/510). MRM was performed in 3% of stage 0 (6/200), 23% (49/209) stage I, 46% (97/209) of stage II and 27% (57/209) of Stage III patients (Figure 1.2). Overall, the rate of BM was 42% among Early Stage Breast Cancer.

Among 41 patients treated with bilateral mastectomy, 10 were positive for BRCA mutation, 6 for family history and 3 for contralateral disease (Fig. 3).

Median age of BM was 53 (range 33-12 y). The local recurrence rate was 8.8% (49/510), and metastatic recurrence rate was 15.6% (79/510). Lymphedema rate was 9.2% (47/510). Using MRM as reference, the Odds Ratio (OR) for lymphedema after BCT and BM were 2.15 (95% CI, 0.84-5.50) and 0.58 (0.28-1.22), respectively (Table 1). With 9.6 years of median follow up, the predictive probabilities of lymphedema after BCT, MRM and BM were 1%, 4%, and 9% respectively (Figures 4.6). Other post surgical complications were more common after MRM and Bilateral Mastectomy compared to BCT (Table 5b). The OR for LR in women with BCT were 1.46 (95% CI: 0.72-2.95), SM 0.27 (0.03-2.13), BM 2.06 (95% CI:0.70-6.06) (Fig. 6).

REFERENCES