Breast Surgeons Urge Against Prophylactic Mastectomy

— But expert society's consensus statement does delineate possible exceptions

Most women with newly diagnosed unilateral breast cancer do not benefit from contralateral prophylactic mastectomy (CPM) and should not routinely undergo the procedure, according to a consensus statement from the American Society of Breast Surgeons (ASBrS).

However, the final decision should account for patient preferences.

"The consensus group agreed that CPM should be discouraged for an average-risk woman with unilateral breast cancer," consensus chair Judy C. Boughey, MD, of the Mayo Clinic in Rochester, Minn., and co-authors wrote in the two-part statement, published online in Annals of Surgical Oncology. "However, the patient's values, goals, and preferences should be included to optimize shared decision making when discussing CPM."

"The final decision whether or not to proceed with CPM is a result of the balance between benefits and risks of CPM and patient preference."

The American Cancer Society (ACS), which has no formal position on the issue, supports the ASBrS recommendation against routine CPM, said ACS Chief Medical Officer Otis Brawley, MD. At the same time, the society supports a woman's right to choose CPM.

"It's a very difficult decision," Brawley told MedPage Today. "We think that any woman who wants to have a prophylactic mastectomy ought to be able to have a prophylactic mastectomy. However, we also believe that if more folks understood the statistics and understood the real facts, fewer people would be getting prophylactic mastectomy than currently are."

The consensus statement follows the position ASBrS expressed in its 2016 contribution to the Choosing Wisely campaign: "Don't routinely perform a double mastectomy in patients who have a single breast with cancer."

The consensus statement consists of an article summarizing the data on risks and benefits of CPM and related issues, and an article that addresses considerations for shared decision-making about CPM.
The data document concluded with a summary of circumstances for considering CPM and for discouraging CPM. The circumstances for considering CPM include patients with a significant risk of contralateral breast cancer; documented carriers of mutant BRCA1/2, strong patient history in the absence of genetic testing, and history of mantle chest radiation before age 30.

Lower risk patients who might also consider CPM include women who are carriers of non-BRCA genes associated with breast cancer (such as CHEK-2, PALB2, p53, and CDH1) and women who have a strong family history of breast cancer, but are BRCA negative and have no family history of BRCA positivity.

Other reasons to consider CPM included a desire to limit contralateral breast surveillance, improve breast symmetry after reconstruction, and manage risk aversion or extreme anxiety.

The statement cites six circumstances for discouraging CPM:

- Average-risk women with unilateral breast cancer
- Advanced cancer index (such as inflammatory breast cancer, T4 or N3 disease, or stage IV disease)
- Increased risk of surgical complications (high comorbidity burden, obesity, diabetes, etc.)
- Women who are BRCA negative but have one or more family members who are carriers
- Male breast cancer, including BRCA carriers

The article on additional considerations for CPM addressed the role of sentinel lymph node (SLN) biopsy, cost issues, psychosocial outcomes, and CPM as a possible quality metric.

The panel concluded that contralateral SLN surgery should not be performed routinely. CPM is cost-effective for BRCA-positive breast cancer, but data on sporadic breast cancer are insufficient.

With respect to psychosocial outcomes, the consensus panel found that 80% to 90% of women who undergo CPM remain satisfied with their decision, but 20% to 30% report dissatisfaction with cosmetic outcomes. CPM does not affect overall quality-of-life outcomes.

CPM should not be adopted as a national quality measure. The panel found limited use of CPM as a quality measure, primarily because of a lack of a clear association with improved outcome and the potential for unintentionally decreasing access to CPM among women who heightened risk of contralateral breast cancer.

The panel also reviewed international perspectives of CPM, and found that CPM rates are increasing in the U.K., but not mainland Europe. Factors influencing the increased use of CPM in the U.K. are similar to those found in the U.S.

Examination of patient perspectives on CPM showed that fear and a desire to take control (the so-called 'Jolie Effect') dominated the decision-making process leading to a decision to undergo CPM. The panel cited a need for additional patient education resources on the risks and benefits, greater patient engagement, and better decision-making guidelines.
The second document concluded with suggestions for a framework of shared decision-making about CPM and provision of adequate counseling. The panel also developed an information template that outlines essential information about CPM that should be communicated to patients considering the procedure.

Responding to the document's reference to the impact of actress Angelina Jolie's openness about her decision to have a bilateral prophylactic mastectomy, Brawley returned to the statistics surrounding breast cancer and CPM.

'[Jolie] had a specific mutation that meant she had an 85% chance of having breast cancer by the age of 75 or so,' he said. 'I see women who have a 15% chance of having breast cancer choosing to do the same thing. The average American woman has a 12% chance of getting breast cancer.'

A shortage of qualified genetic counselors accounts for much of the confusion and misunderstanding about breast cancer risk, Brawley added. Currently, about 800 counselors are available nationwide, and they must spread their time among patients with dozens of different types of genetic orders, many of which do not involve cancer.

Boughey and co-authors disclosed no relevant relationships with industry.