Breast surgery in SA 2017: Quo vadis?

This month's edition of the SAJS publishes articles from Southern African authors collated under the theme of breast surgery. Each paper is informative and interesting, but perhaps more importantly this editorial focus can cause us to reflect on the status of breast surgery in South Africa from the perspectives of clinical practice and research.

Two papers relate to plastic and reconstructive surgery topics. Joy and Segwapa, from the Sefako Makgatho Health Science University, Pretoria, describe 9 cases of gynaecomastia treated with mastectomy via circumareolar approach. The patients are a combination of men with gynaecomastia and women undergoing gender reassignment surgery. They emphasize meticulous measurements and techniques to ensure that the nipple areolar complex is retained in a suitable position for best aesthetic outcome. This is an interesting and practical article for surgeons who perform gynaecomastia surgery - a procedure that straddles the fields of general surgery and plastic surgery. Few surgeons perform a large number of these procedures, as they are not adequately funded by medical aid schemes in the private sector and pushed to the back of the waiting list by oncology priorities in state hospitals.

Wamalwa and Tilman, from the University of Nairobi, have written an informative paper detailing the current concepts of anatomy and technique when performing reduction mammaplasty. It is a well established procedure from an aesthetic and reconstructive perspective, with very high patient satisfaction rates, and its relevance is increasing as it is more commonly performed as an adjunctive procedure in the contralateral breast at the time of mastectomy for breast cancer.

Mutebi and colleagues from the University of Cape Town present a retrospective review of patients diagnosed with DCIS within the breast cancer clinic service at Groote Schuur Hospital. The incidence of 1.1% is reflective of a population group with no access to screening, and is reminiscent of the incidence of DCIS seen in the western world in the 1960s and early 70s. It is a further reminder that the South African public health system needs a major shake up, and must refocus on how to diagnose breast cancer earlier and more efficiently.

As more and more patients live longer after the initial diagnosis of breast cancer, clinicians see an increasing number of late recurrences and contralateral metachronous breast cancer. Prof. Mannel, from the University of Witwatersrand, has submitted an article on the risk factors for breast cancer recurrence, categorised by patient, treatment and biological factors, producing a succinct and helpful overview of this topic.

Reddy and colleagues from the University of KwaZulu Natal have prepared a literature review on breast cancer and HIV. The paucity of meaningful and reliable data is striking. Even more striking is the fact that only one of the five studies considered to be of adequate quality to be included in the review originates from Southern Africa. Patients who have HIV and breast cancer are younger, have more advanced disease at the time of diagnosis, and suffer from more chemotherapy complications than their HIV negative counterparts. It is clear that the standards of care for these patients must be defined and studied prospectively, preferably by clinicians working in Southern African centres.

The articles in this edition of SAJS cover a broad spectrum of topics in breast cancer surgery. Reading beyond this research, what should the focus of breast surgery research in South Africa be over the next decade? In terms of clinical care, we must renew our efforts to make early diagnostic services available to as many people as possible. It is clear that there is a new cadre of surgeons with a specific interest in breast surgery arising. In this context, the College of Surgeons and the HPCSA need to work towards finalising a certificate in Breast Surgery that will allow such individuals clear career paths and equitable professional status. This is important even as we acknowledge that the majority of clinical services will still be rendered by generalists with appropriate support from academic centers, as is the case with other sub-specialities in surgery.

Providing breast surgery services in our resource constrained environment often stimulates management and research questions unique to our environment: What is an acceptable waiting time for surgery? Can we reasonably deny reconstructive procedures to allow more patients access to overbooked surgical lists? Is a mastectomy and axillary clearance for early breast cancer an outdated procedure or an acceptable solution for patients who have very limited access to radiotherapy, follow-up, mammography and systemic oncological treatment? How do we balance the benefits of expensive oncological treatments such as trastuzumab against the need to fund improvements in diagnostic services?

These are among the many dilemmas we face on a regular basis that need data, research and thoughtful analysis. South African clinicians and researchers who provide surgical services in both relatively well resourced academic centres and also under resourced peri-urban and rural health facilities are ideally placed to answer these questions which are relevant not only to our own country but also middle and lower income countries throughout the world. By conducting sound, appropriate research, we will continue to add strength to our advocacy for improvements in the care and outcomes for patients within our service.

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