

Breast cancer and informed consent

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For nearly a century radical mastectomy, with or without irradiation, has been the accepted treatment of operable cancer of the breast. In the United States, although not in England or Scandinavia, it is still employed in the majority of patients with operable breast cancers. With such overwhelming endorsement from the surgeons of the United States the status of this operation would appear to be established beyond question, at least from the standpoint of customary practice. Yet recent developments in the now controversial field of the treatment of breast cancer raise the question of whether or not the patients who submit to radical mastectomy are doing so with informed consent. The following are some of the questions that might be asked.

Are patients with breast cancer informed by their surgeons that randomized studies in England have shown that the survival rate after simple mastectomy and irradiation is just as high as after radical mastectomy and irradiation?¹ Are they told that a randomized Scandinavian study has shown that survival rates, at 5 and 10 years, are the same after simple mastectomy and irradiation and after ultraradical operations?²

Have they been informed that there are several series of patients,³ including one controlled study,⁴ in which local excision of breast cancers followed by irradiation has given results equal to or perhaps superior to those following radical mastectomy? Have they been informed that in women with small, peripherally located cancers, wide local excision without irradiation has given results that are comparable in both survival and local recurrence with those following radical operations with or without irradiation?⁵ When a patient is treated by prophylactic irradiation after radical mastectomy is she informed that this has been found to double her chances of having lymphedema of the arm, and to greatly increase the severity of the edema if she gets it?⁶ Finally, has she been informed that randomized studies here and abroad have shown prophylactic postoperative irradiation, which contributes so heavily to the limitation of motion of the arm, contributes nothing to survival?^{7, 8} It has even been suggested that the irradiation may increase or at least hasten the appearance of systemic metastasis.^{9, 10}

There are many variations to the above theme, including the report that when patients with occult metastasis in nodes are treated by simple mastectomy without irradiation the results of treatment are just as good when axillary dissection is deferred until the metastases are palpable as when the axillary nodes are removed at the original mastectomy.¹¹ It seems, in short, that in selected cases there is a place for a variety of treatments, but that the exact indications for each treatment have not yet been defined.

Throughout the world, authorities

on the treatment of breast cancer have their individual ideas on how to treat the disease, but on one point almost all agree. There is no proof that any of the treatments, varying from local excision with or without irradiation to ultraradical mastectomy with or without irradiation, result in a higher rate of survival than any of the others. The situation has been summarized by Dr. Bernard Fisher,¹² Chairman of the National Surgical Adjuvant Breast Project, who in a plea for randomized studies of the results of various treatments said that we simply do not know which method is best.

To the woman with breast cancer, survival is usually the most important consideration. But some women prefer to gamble on survival rather than lose the breast and risk the deformity and dysfunction they associate with the treatment of breast cancer. Often it is this consideration, rather than ignorance, that impels women to conceal their disease until it is advanced. It is the same type of death-defying choice that is made by well-informed men who persist in smoking to excess.

If women were aware of the fact that there is no proven difference in survival after various types of treatment, it is unlikely that many of them would accept the deformity that results from the conventional radical mastectomy or the risk of lymphedema and limitation of motion that is so greatly increased when the axilla is dissected and irradiated. On the other hand, when patients are told that simple mastectomy or modified radical mastectomy removes the entire breast, whereas local excision of the tumors removes only a part of the breast, and leaves the rest susceptible to the growth of a new cancer, the

responses of the patients in our experience have been mixed. Many older women, and many women with a strong family history of breast cancer, who have followed their relatives through the terminal days of this disease, elect to have the breast removed. Many unmarried women, widows or divorcees, to whom the breast is an important symbol of femininity, prefer partial mastectomy.

For too long surgeons have assumed the entire burden of deciding how patients with breast cancer should be treated. In the days when it was agreed that radical mastectomy was best, there was no alternative. Today there is no agreement, and therefore the surgeon is obligated to inform the patient of the facts. Only when the patient is allowed to participate in the decision can she accept an operation on her breast with what can be known, ethically, as "informed consent."

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