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The Journal of Breast Health

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The publication language of the journal is both in Turkish and English, and it is published quarterly on January, April, July and October.

The target audience of the journal includes specialists and medical professionals in general surgery and breast diseases.

The editorial policies and publication process are implemented in accordance with rules set by the International Committee of Medical Journal Editors (ICMJE), World Association of Medical Editors (WAME), Council of Science Editors (CSE), European Association of Science Editors (EASE), Committee on Publication Ethics (COPE), and the Heart Group.

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The journal's guidelines, technical informations and the required forms are available in the journal's web page.

Statements or opinions expressed in the manuscripts published in the journal reflect the views of the author(s) and not the opinions of the Turkish Federation of Breast Diseases Societies, the editors, the editorial board and/or the publisher; the editors, the editorial board and the publisher disclaim any responsibility or liability for such materials.

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From the Editor

ENDOSCOPIC ASSISTED ONCOPLASTIC BREAST SURGERY

Minimal invasive endoscopic surgery have been widely used in many fields of surgery. Oncoplastic breast surgery is one of the rare field where the breast surgeons have not met yet the endoscopic surgery. The late meeting of the breast surgeons with endoscopic surgery may be due to the inherent low morbidity, low pain, small incisions and successful cosmetic results of the oncoplastic breast surgery techniques. It is only after Kompatscher used endoscopy for capsulotomy in breast for the first time in 1992 that the breast surgeons became interested with endoscopic techniques in breast surgery.

Endoscopic oncoplastic breast surgery represents a minimal invasive approach with the aim of both removing cancer safely and also restoring the body image. Less noticeable scar, excellent cosmetic outcomes and recently reported relatively long term safety lead to be established the technique as a routine clinical practice in some institutions of some Asian Countries such as Japan, Korea and China.

Operative techniques for both endoscopic breast conserving surgery and endoscopic nipple/areola/skin sparing mastectomy have been described in detail and being widely used. Tumor localization and marking the proposed resection margins on the skin are achieved preoperatively by injections of colored dye at several points at the tumor periphery by radiologic guidence. The purposed surgical margin is marked usually 2 cm distant from the tumor edge.

Two different working planes are used during the surgery. One of them is subcutaneous plane where the skin flap is developed, and the other one is sub-mammary plane. Skin incisions are placed usually in either periareolar region or in the axilla. Sentinel lymph node incision in the axilla is used for retromammary dissection while the periareolar incision is the route for subcutaneous dissection and for retrieving the resected specimen. Light guided specific mammary retractors are also used during subcutaneous dissection. Wound protectors are usually used to ensure adequate visualization and to protect the periareolar and axillary skin.

Endoscopic dissection between the pectoralis muscle and the posterior breast is performed with various retractors such as Ultra Retractor. Endoscopic breast retractors allow for a magnified view and extensive posterior breast dissection. Subcutaneous tunneling method is the most commonly used technique for endoscopic subcutaneous dissection. Septa between the tunnels are then dissected under endoscopic guidence. The tumescent technique in which epinephrine containing physiological saline is injected into the subcutaneous tissue provides more easy and bloodless dissection. Bipolar scissors and electrocautery are used for tissue dissection and coagulation in both subcutaneous and retromammary dissection planes. Colored dye injected at the tumor periphery or at the breast boundary determines the extent of the dissection.

To repair the defect of the excised breast tissue, usually the volume displacement technique are used. Widely dissected mammary gland and adipose tissue are mobilized to the defect and sutured by the help of light guided mammary retractors.

Endoscopic assisted breast surgery provides, in general, excellent cosmesis with minimal scar. Less noticeable scar is the most important advantage of endoscopic breast surgery. Most of the patients are satisfied with the provided cosmesis.

An average operation duration time for endoscopic assisted breast surgery has been reported as equal or 30-50 minutes longer or 20-25 minutes shorter than open breast surgery. The different results can be attributed to the different techniques used in. In general the reported longer operative durations are due to woking in a limited and small surgical dissection field.

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From the Editor

Complication rates of endoscopic breast surgery are similar to open breast surgery rates. The most serious complications related with the technique are skin, muscle and nipple necrosis which are comparable to the results of the open procedures. Intraoperative blood loss is not different between endoscopic and open breast surgery.

A positive surgical margin rate in endoscopic breast surgery is between 0% to 25% and is not inferior to that open breast surgery. Local recurrens following endoscopic breast surgery is infrequently reported. Eventhough having a shorter follow-up time with an average of 24 months there was no recurrens in reported studies. On the other hand, overall survival rates following endoscopic and open breast cancer surgery are comparable with an average 20 months follow-up. Endoscopic breast surgery leads to an equivalent risk with open breast surgery for local and distant disease recurrence. Overall survival also demonstrated favorable results with endoscopic breast surgery in some studies. However the follow-up periods are too short to compare the endoscopic breast surgery with open surgery. It looks reasonable to wait for the results with longer follow-up before having a judgement about oncologic efficiency and safety of the endoscopic breast cancer surgery.

The current disadvantage of endoscopic breast surgery is the additional cost related to the use of some new devices which are not approved yet by health insurance providers for breast cancer surgery.

As a result, it looks like that endoscopic breast surgery is a new field that the breast surgeons will deal with for the forthcoming years.

Gürsel Soybir