

cancer incidence after mammoplasty in higher-risk patients are necessary to assess the possible impact on MBC prevention and the overall survival of these patients. Although this study has limitations concerning its analyses and conclusions, the authors described important aspects that are relevant to the informed treatment decision-making process.

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Competing interests: None declared.

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DRS. HORO, ACKER AND BODY REPLY

We read with interest your reaction to the article on mammoplasty and histologic results.¹ The objective of this work was to show the opportunity that the histologic assessment of the glandular tissue offered during mammoplasty for symmetry in the search for occult lesions in the opposite breast in these high-risk women.

We reported that we didn't find in situ or invasive carcinomas, but rather borderline (15.6%), benign (38.9%) and normal (45.5%) lesions. We also agree that eventual bias may have existed, and we reported this in our paper.

Other authors found carcinomas even in women who didn't present high risk for breast cancer.² Yet it is difficult to compare these series because they concern different populations with nonstandardized preoperative diagnostic means. We insist, on the other hand, like most authors, on the importance of such verification in these high-risk women.

We think that an effective preoperative management must help reduce the impact of these subsequent cancers.

Concerning the later occurrence of this type of metachronous cancer in the contralateral breast, we assessed their impact in 273 women who had undergone a breast reconstruction³ in our department. During a mean follow-up of 6.6 years we noticed a prevalence of 1.8% with a cumulated impact of 4.6 person-years. The histologic cancers were ductal and invasive in 80% of cases. Studies on cancer of the contralateral breast are disparate, and they often raise methodologic problems. We notice diversity in the definition of cases among studies and a variability of study populations and duration of follow-up. Despite these methodologic biases, all the studies are unanimous on the fact that a cancer developing in one breast increases the risk of cancer in the contralateral breast. The risk is important in the first 5 years after the initial treatment.⁴ The 5 contralateral cancers detected in our series were discovered after a mean time of 6.3 years.

Mammography remains the pillar for detecting contralateral breast cancer; however, the risk of occult cancer varies from 4% to 24%.⁵ Besides, the impact of mammographic surveillance of the opposite breast on mortality reduction remains to be proven.⁶ Moreover, the benefit of mammography during the surveillance of the contralateral breast in young women is controversial (low sensitivity and

specificity, and risk of radio-induced cancers). In our series, mammography helped detect 80% of contralateral cancers.

The positive predictive value of MRI-induced biopsies varies from 49% to 80% in the literature, which makes clinicians advise against prophylactic mastectomy for lesions detected by MRI, particularly because the specificity of MRI remains low, and the impact of the diagnosis of the contralateral lesions on patients' survival is still not well known.⁵

The probability of locating a tumour in the contralateral breast after a breast reconstruction is high. The diagnosis of a relapse must not be delayed by mammoplasty scars and glandular resection can constitute an opportunity to detect occult lesions.

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Competing interests: None declared.

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