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RICK LINFORTH
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Oncoplastic Breast Surgery

TIG Meeting

27th June 2025

09:10 Avoiding litigation in oncoplastic breast surgery

Mr Rick Linforth, Bradford

Here, there and on a beach …
Durham / HM Coroners Court

This presentation is available to download @

https://www.ricklinforth.com/medicolegal-reports.html

NHS medical negligence liabilities hit £58.2bn amid calls to improve patient safety

Public accounts committee called the record sum 'jaw-dropping' and criticised inaction to reduce errors in a damning report

Denis Campbell *Health policy editor*

Wed 14 May 2025 00.01 BST

Wes Streeting announces investigation into 'failing' NHS maternity services

Health secretary launches national inquiry into care of mothers and babies in England, saying there is 'too much passing the buck'

Tobi Thomas *Health and inequalities correspondent*

Mon 23 Jun 2025 18.42 BST

HM Coroner's Investigations and Inquests into the Deaths of the Patients of Ian Paterson

HOME | OPENED INQUESTS | LATEST NEWS | TIMETABLE | RULINGS | TRANSCRIPTS | INTERESTED PERSONS | MEDIA PROTOCOL | TEAMS | PREVIOUS REPORTS | CORONER'S ROLE | SUPPORT | CONTACT US | FACILITIES HM CORONER HAS PROVIDED TO ASSIST MR PATERSON'S PREPARATION FOR THE INQUESTS

Jailed surgeon's mastectomies inadequate - inquest

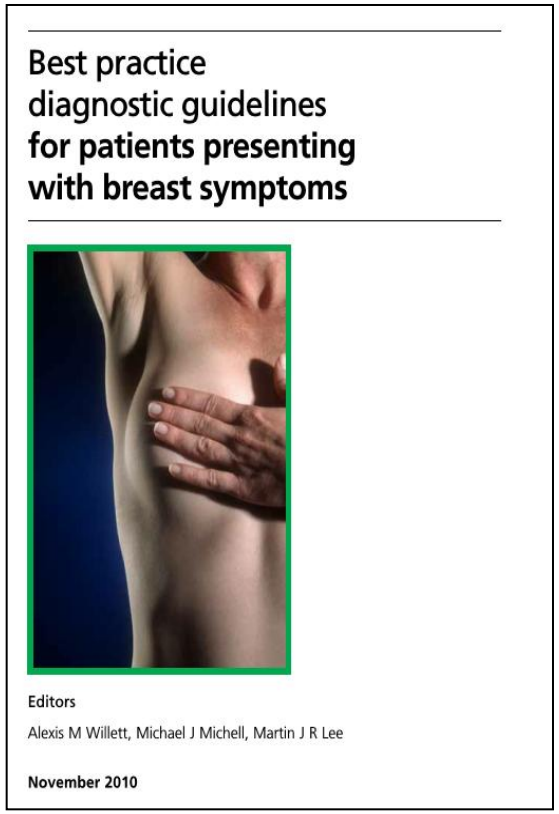
Ian Paterson is serving a 20-year sentence for wounding 10 of his former patients

Inquest costs:
£7 Million
Birmingham City Council

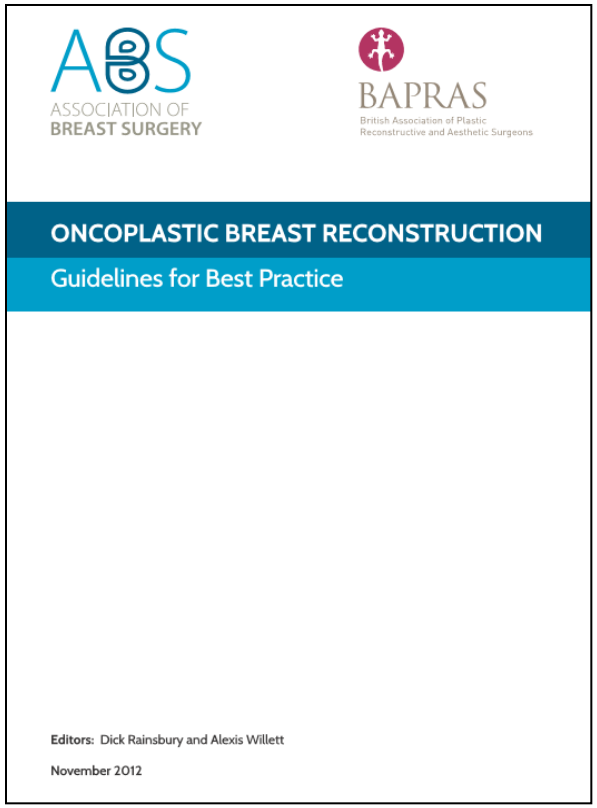
Legal claims paid out previously

Spire Healthcare to pay £27m towards £37m compensation fund for 750 victims of breast surgeon Ian Paterson

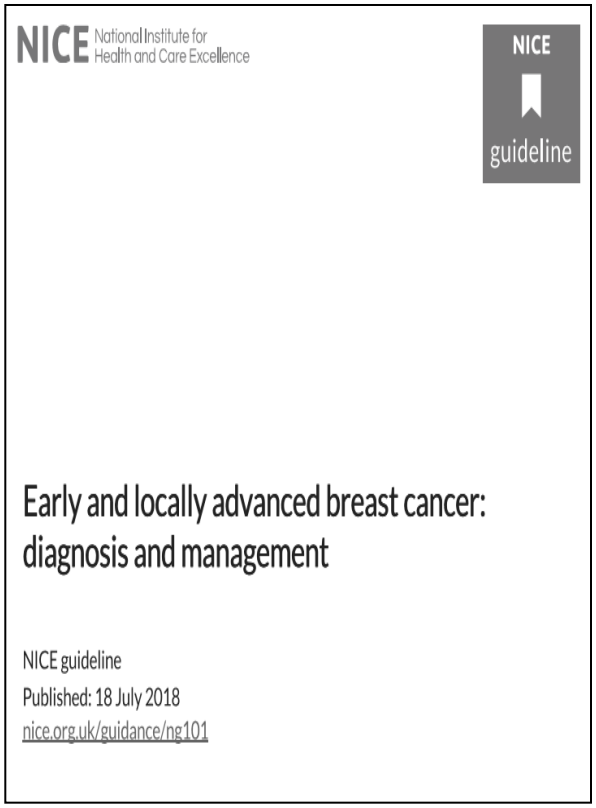
Standard of Care:--What is it for Breast?



Best Practice Guidelines



Oncoplastic guidelines 2012 updated 2021



Nice 2009/2018/April 25

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https://associationofbreastsurgery.org.uk/professionals/information-hub

Litigation in breast surgery: unique insights from the English National Health Service experience

R. L. O'Connell[1,*], N. Patani [2,3], J. T. Machin[4,5], T. W. R. Briggs[5,6], T. Irvine[5,7] and F. A. MacNeill[1,5]

[1]Department of Breast Surgery, Royal Marsden NHS Foundation Trust, London, UK
[2]Department of Breast Surgery, University College Hospital, London, UK
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[5]National GIRFT programme, NHS England and Improvement, UK
[6]Sarcoma Unit, Royal National Orthopaedic Hospital, Stanmore, UK
[7]Department of Breast Surgery, Royal Surrey County Hospital, Guildford, UK

*Correspondence to: Department of Breast Surgery, Royal Marsden NHS Foundation Trust, Fulham Road, London SW3 6JJ, UK (e-mail: roconnell@doctors.org.uk)

Table 2 Causes of 449 litigation claims related to breast surgery

Cause of litigation claim	*n*
Delay in diagnosis or treatment	
Delay in diagnosis	121
Delay in starting treatment	26
Surgical decision-making or clinical judgement	
Surgical planning decision-making	55
Clinical decision dissatisfaction	46
Consent/communication	
Consent	57
Communication-related issue	12
Operative	
Cosmetic outcome dissatisfaction	121
Incomplete excision of benign lump	10
Incomplete excision of malignant lump	12
Wrong-site surgery	4
Wrong-side surgery	0
Intraoperative injury	14
Retained foreign body	15
Breast implant-related	78
Postoperative	
Surgical-site infection	42*
Other infection	1
Venous thromboembolism	0
Pressure sore	4
Other complication not requiring surgery	14
Other complication requiring further surgery	27

32% Delays.
27% Cosmetic outcome
22% Decision making
17% Implant related
12% Consent
9% infection related

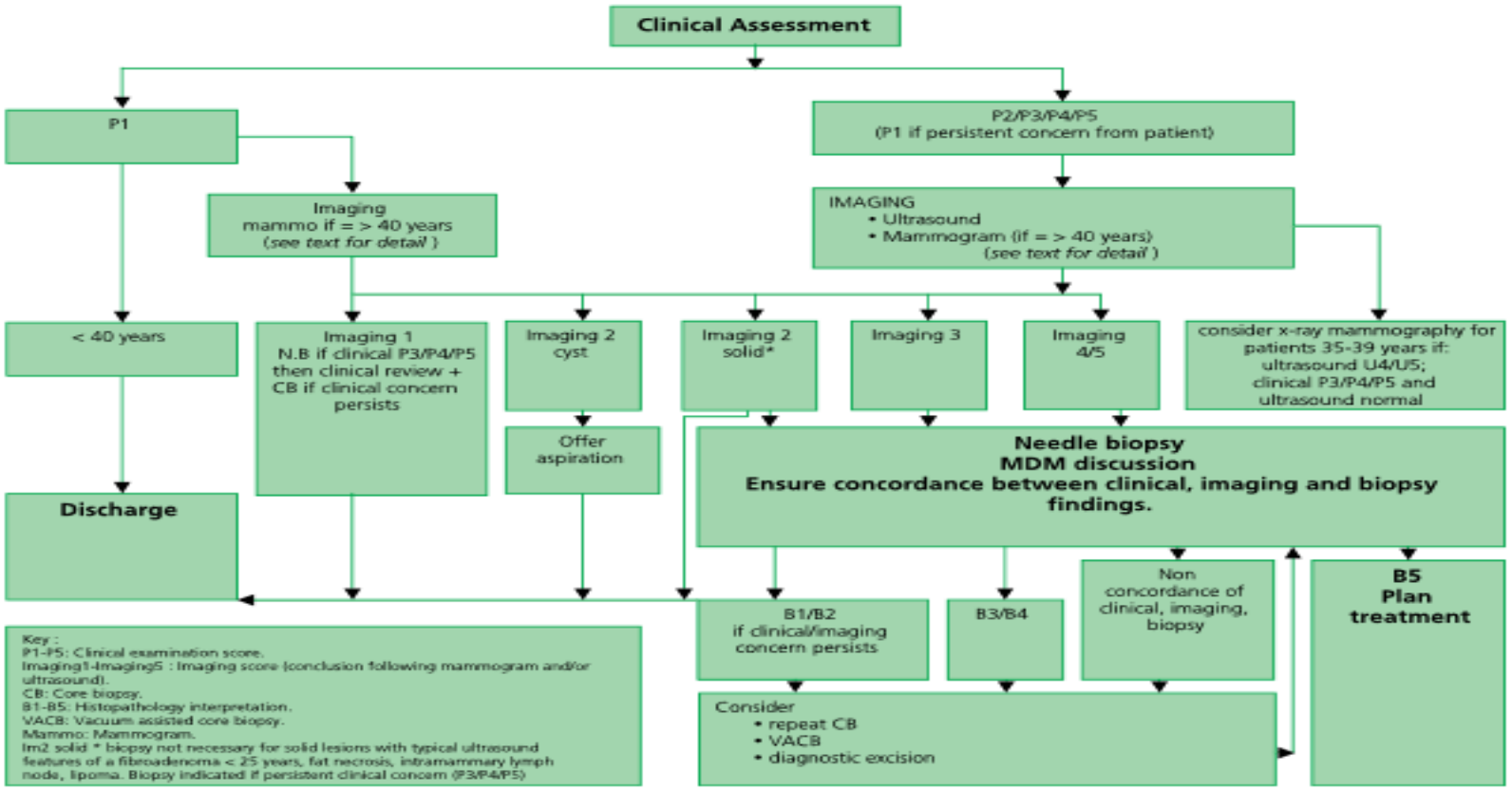
BJS Open, 2021, zraa068

DOI: 10.1093/bjsopen/zraa068

Original Article

1. Delays

5. Algorithm A. Assessment: Lump/Lumpiness



Missed cancers are usually P2-3 U1,
without review or biopsy in Woman under 50

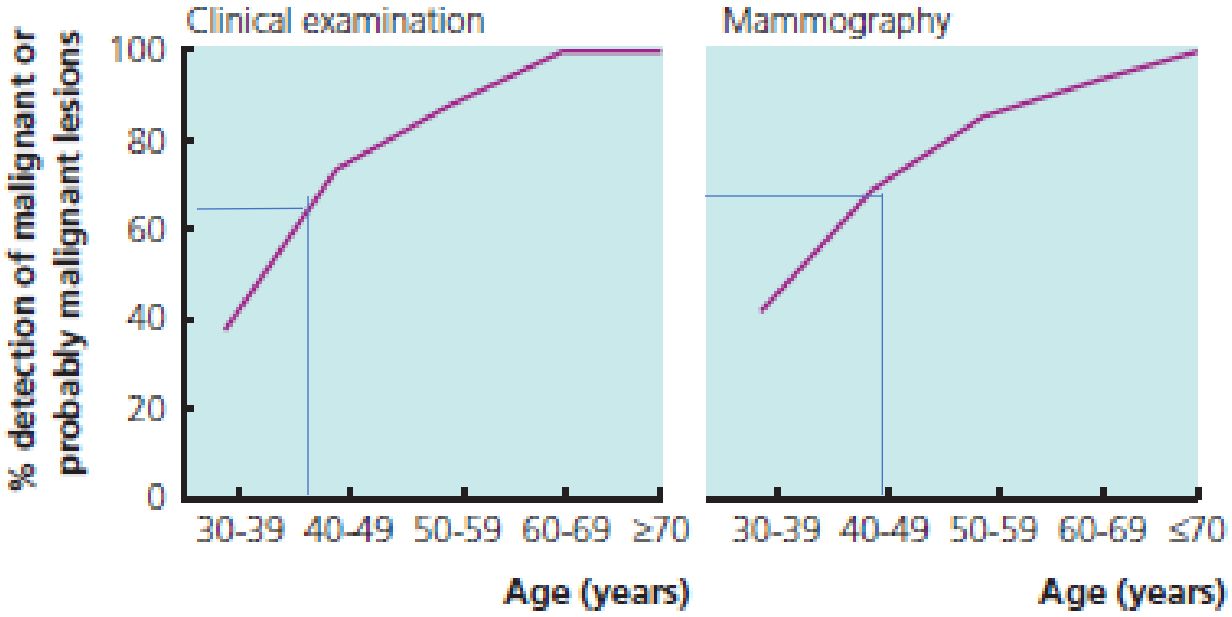


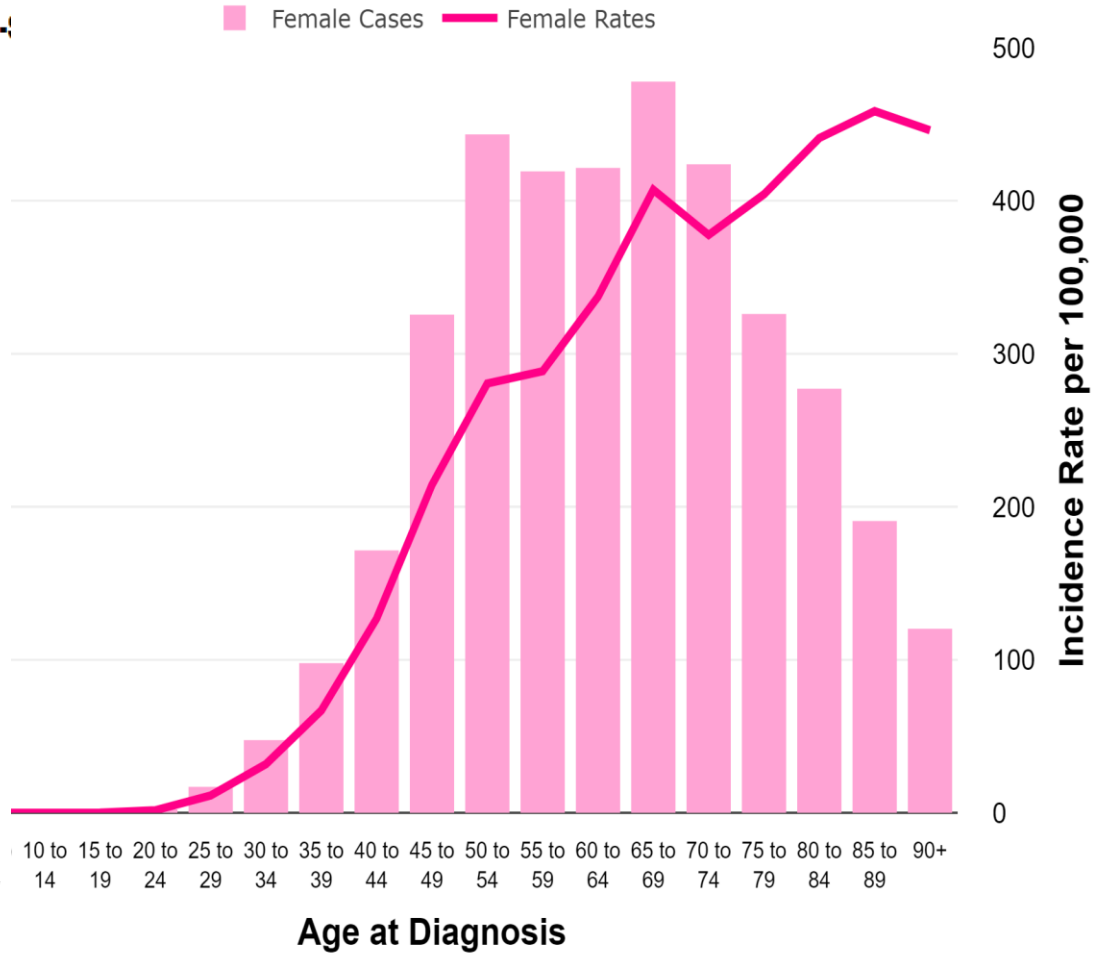
Figure 1.16 Sensitivity of clinical examination and mammography by age in patients presenting with a breast mass.

Table 1.6 Advantages and disadvantages of techniques for assessment of breast masses.

Technique	Advantages	Disadvantages
Clinical examination	Easy to perform	Low sensitivity in women ≤50 Operator dependent*
Mammography	Useful for screening women aged ≥50	Requires dedicated equipment and experienced personnel Low sensitivity in women ≤50 Unpleasant (causes discomfort or actual pain)

Average Number of New Cases Per Year and Age-S
per 100,000 Female Population, UK

Age Range	Female Cases	Female Rates
0 to 04	0	0.0
05 to 09	0	0.0
10 to 14	0	0.0
15 to 19	2	0.1
20 to 24	33	1.6
25 to 29	254	11.4
30 to 34	713	31.8
35 to 39	1,467	66.9
40 to 44	2,573	127.0
45 to 49	4,884	214.4
50 to 54	6,651	280.6
55 to 59	6,289	288.6
60 to 64	6,323	337.3
65 to 69	7,168	407.2
70 to 74	6,358	377.7
75 to 79	4,890	404.3
80 to 84	4,158	441.0
85 to 89	2,861	458.6
90+	1,805	446.1
All Ages	56,428	169.9



289 cancers in woman under 30
(1-2 per unit) (2017-19)

2.2	One-stop assessment
QI9	• At one-stop assessment all the required elements of triple assessment are performed during a single visit. This provides: – a basis for definitive diagnosis in the majority of patients – reassurance with no need for further attendance in most patients with non-malignant conditions – information for multidisciplinary meeting (MDM) treatment planning prior to review of those diagnosed to have cancer • Some patients do not require all the elements of triple assessment, as outlined below and defined in the Algorithms. This includes those with: – resolved symptoms and no clinical abnormality – clearly identified benign conditions with no other suspicious features found on clinical and imaging assessment such as: ▪ areas of benign breast change and diffuse nodularity without a dominant mass ▪ simple cysts whether aspirated or not ▪ breast pain ▪ non-bloody nipple discharge ▪ gynaecomastia

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Beware the focal nodularity-P3

Needs a core biopsy!

…At the very least bring back for review at 6 weeks if not biopsied

Willett et al : Best Practice 2010

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Association of Breast Surgery
Summary Statement

ABS ASSOCIATION OF BREAST SURGERY

INVESTIGATION AND MANAGEMENT OF GYNAECOMASTIA IN PRIMARY & SECONDARY CARE

Don't forget the blokes! 300 male breast cancers a year

GYNAECOMASTIA IN THE BREAST UNIT

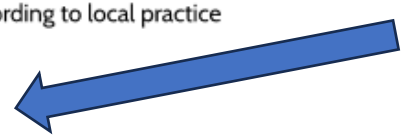
Gynaecomastia does not require all aspects of triple assessment

1. History:
   - Drug history
   - Alcohol history
   - Recreational drug use
   - Steroid use
   - Family history

2. Clinical examination:
   - Chest, bilateral
   - Nodal areas: axillae and supraclavicular fossae
   - Gynaecomastia can be described according to the Simon Classification (Appendix 1)

3. Imaging
   - Bilateral pseudogynaecomastia: No imaging
   - Bilateral gynaecomastia P2: No imaging
   - Unilateral lump in age <25years: No imaging
   - Unilateral lump in age >25 years *and* P2: No imaging
   - Unilateral lump in age >25years *and* P3+: USS +/- mammogram according to local practice

4. Pathology
   - Biopsy only if one or more of the following: P3+, M3+, U3+



Any P3 gets a biopsy !

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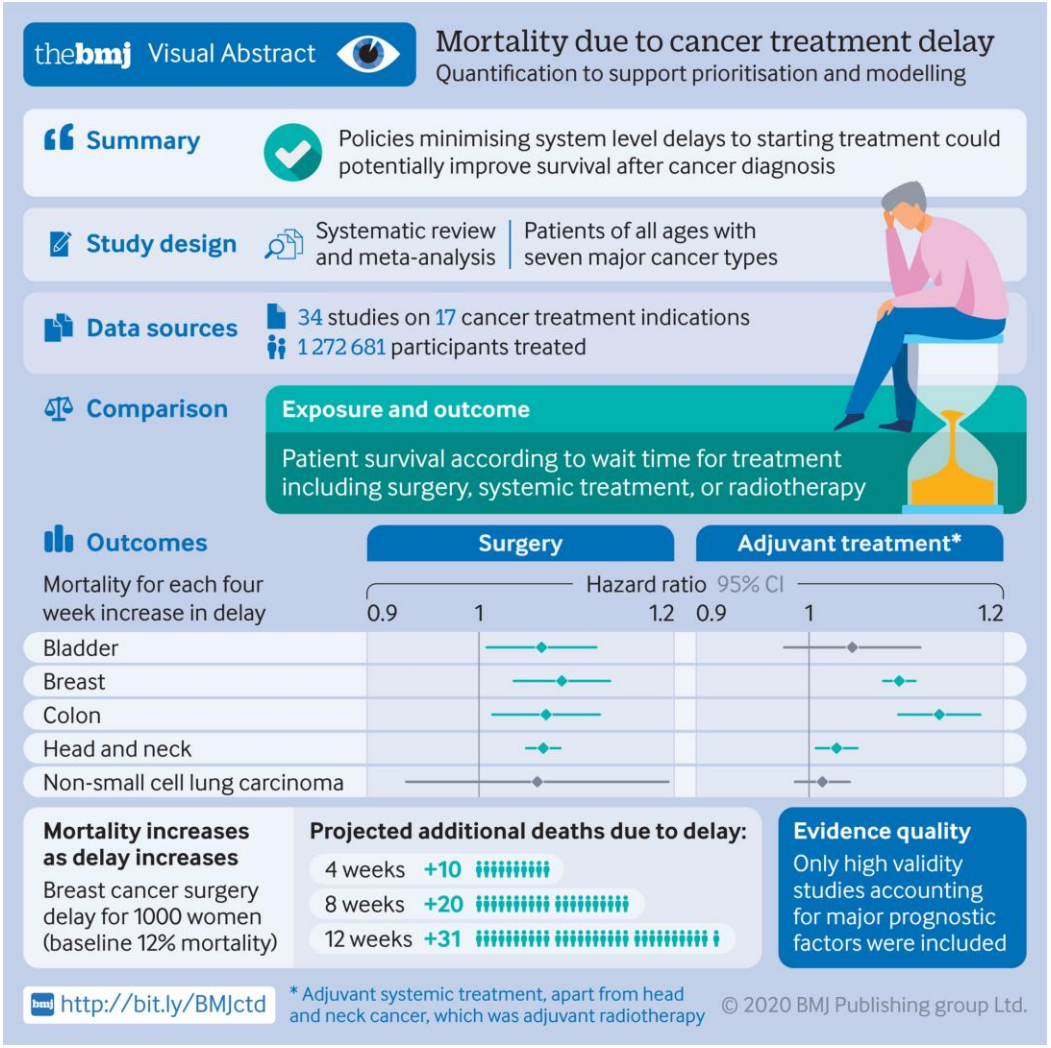
Mortality due to cancer treatment delay: systematic review and meta-analysis

Timothy P Hanna,[1,2,3] Will D King,[3] Stephane Thibodeau,[2] Matthew Jalink,[1,2] Gregory A Paulin,[2] Elizabeth Harvey-Jones,[4] Dylan E O'Sullivan,[3] Christopher M Booth,[1,2,3,5] Richard Sullivan,[6] Ajay Aggarwal[4,6,7]



Mortality risk increases by 1.08 for every 4 week delay.

Young woman have more grade 3 and triple negative breast cancers

What to do with the axilla ?

ASCO Special Articles

Check for updates

Sentinel Lymph Node Biopsy in Early-Stage Breast Cancer: ASCO Guideline Update

Ko Un Park, MD[1]; Mark R. Somerfield, PhD[2]; Nirupama Anne, MD[3]; Muriel Brackstone, MD, PhD[4]; Alison K. Conlin, MD[5]; Henrique Lima Couto, MD, PhD[6]; Lynn T. Dengel, MD, MSc[7]; Andrea Eisen, MD[8]; Brittany E. Harvey, BS[2]; Jeffrey Hawley, MD[9]; Janice N. Kim, MD, MS[10]; Nwamaka Lasebikan, MBBS[11]; Elizabeth S. McDonald, MD, PhD[12]; Deepti Pradhan, PhD[13]; Samantha Shams, MD[14]; Raymond Mailhot Vega, MD, MPH[15]; Alastair M. Thompson, MD, MBChB[16]; and Mylin A. Torres, MD[17]

DOI https://doi.org/10.1200/JCO-25-00099

Association of Breast Surgery

Axillary Guidelines Update

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Honorary Secretary and Trustee
ASSOCIATION OF BREAST SURGERY

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Overview of axillary management in early breast cancer

Presenter: Gurdeep S. Mannu D.Phil FRCS
University of Oxford

Early Breast Cancer Trialists' Collaborative Group (EBCTCG)
Writing Committee: Gurdeep Mannu , Graham Beake, Richard Berry, David Dodwell, Robert Hills, Paul McGale, Stewart Anderson, Ian Campbell, Armando Giuliano, Reshma Jagsi, Thorsten Kuhn, Rebecca Llewelyn-Bennet, Terry Mamounas, Robert Mansel, Pascal Roy, Emiel Rutgers, Nisha Sharma, Sandra Swain*, Jonas Bergh*
(*joint senior co-authors)

Everything is changing …

The Journal of Clinical Investigation RESEARCH ARTICLE

Evolutionary history of metastatic breast cancer reveals minimal seeding from axillary lymph nodes

Ikram Ullah,[1] Govindasamy-Muralidharan Karthik,[1] Amjad Alkodsi,[2] Una Kjällquist,[1] Gustav Stålhammar,[1] John Lövrot,[1] Nelson-Fuentes Martinez,[3] Jens Lagergren,[4] Sampsa Hautaniemi,[2] Johan Hartman,[1,3] and Jonas Bergh[1,5]

[1]Department of Oncology and Pathology, Karolinska Institute, Stockholm, Sweden. [2]Genome-Scale Biology Research Program Unit, Faculty of Medicine, University of Helsinki, Helsinki, Finland. [3]Department of Clinical Pathology, Karolinska University Hospital, Stockholm, Sweden. [4]Department of Computational Biology, Royal Institute of Technology, Stockholm, Sweden. [5]Radiumhemmet – Karolinska Oncology, Karolinska University Hospital, Stockholm, Sweden.

J Clin Invest. 2018;128(4):1355-1370. https://doi.org/10.1172/JCI96149.

"Axillary lymph nodes are the Speedometer of breast cancer growth."

They tell you how fast and how long the disease is growing….but no treatment benefit.

Avoid Lymphoedema stop clearing for 1-2 nodes positive. Use TAD after Neoadjuvant .

2. Implants and Consent

Benefits

- Relatively ‘simple’
- Small scars, no donor site scars
- Reversible and replaceable
- Short anaesthesia and recovery period

Problems

- Engineering/prosthetic limitations/deflation
- Foreign body/infection
- Deterioration/wrinkling
- Capsule formation
- Limited projection/ptosis
- Poor Inframammary fold
- ALCL/ BII

ARTICLE IN PRESS

European Journal of Surgical Oncology xxx (xxxx) xxx

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European Journal of Surgical Oncology

journal homepage: www.ejso.com

Oncoplastic breast surgery: A guide to good practice

A. Gilmour [a], R. Cutress [b], A. Gandhi [c], D. Harcourt [d], K. Little [e], J. Mansell [f], J. Murphy [g], E. Pennery [h], R. Tillett [i], R. Vidya [j], L. Martin [e, *]

[a] Canniesburn Plastic Surgery Unit, Glasgow Royal Infirmary, United Kingdom
[b] University of Southampton and University Hospital Southampton, United Kingdom
[c] Manchester Academic Health Sciences Centre & Manchester University Hospitals NHS Trust, Manchester, United Kingdom
[d] Centre for Appearance Research, University of the West of England, Bristol, United Kingdom
[e] Liverpool Breast Unit, Liverpool University Foundation Trust, United Kingdom
[f] Gartnavel General Hospital, Glasgow, United Kingdom
[g] Manchester University Hospitals NHS Trust, United Kingdom
[h] Breast Cancer Now, United Kingdom
[i] Royal Devon and Exeter NHS Trust, Exeter, United Kingdom
[j] The Royal Wolverhampton NHS Trust, Wolverhampton, United Kingdom

- The origin of the specific mesh should be discussed.
- Whether the mesh remains permanently or is expected to be absorbed.
- Patients should be informed of local and global experience with the mesh used including uncertainty regarding long term outcome.
- Knowledge and acceptance that the reconstruction involves a breast implant.
- Patients should be aware that revisional surgery is frequent in the early stages following reconstruction.
- That a drain may be left in-situ for up to two weeks.

Patients need to be aware of the risks of complications, local and personal complication rates. Complications are common in implant only mesh assisted or dermal sling procedures. By 3 months national rates are [68].

- Readmission - 18%.
- Infection - 25%.
- Reoperation - 18%.
- Implant loss - 9%.

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Know your own/unit data

1. Mesh use
2. Implant losses
3. Infection rates
4. Re-admissions

Discuss each and document in letter

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Systematic Review and Meta-Analysis

Medicine®

OPEN

The role of postmastectomy radiation therapy in patients with immediate prosthetic breast reconstruction

A meta-analysis

Yun Pu, MD, Tong-Chun Mao, MD, Yi-Ming Zhang, MD, Shao-liang Wang, PhD*, Dong-Li Fan, PhD*

Grade 3-4 capsular contracture 5-fold increase

Implant loss rate 2.6 fold increase at 25%

Patient satisfaction…significantly reduced

10-year complication rate is 52%.

Some good news about RT

ORIGINAL ARTICLE

Omitting Regional Nodal Irradiation after Response to Neoadjuvant Chemotherapy

Authors: Eleftherios P. Mamounas, M.D., Hanna Bandos, Ph.D., Julia R. White, M.D., Thomas B. Julian, M.D., Atif J. Khan, M.D., Simona F. Shaitelman, M.D., Mylin A. Torres, M.D., +20 , and Norman Wolmark, M.D. Author Info & Affiliations

Published June 4, 2025 | N Engl J Med 2025;392:2113-2124 | DOI: 10.1056/NEJMoa2414859 | VOL. 392 NO. 21

B-51

No benefit of RT for Cn1 to pN0 after Neoadj chemo.

GS2-03: Does postmastectomy radiotherapy in 'intermediate-risk' breast cancer impact overall survival? 10 year results of the BIG 2-04 MRC SUPREMO randomised trial: on behalf of the SUPREMO trial investigators

Presenting Author(s): Ian Kunkler

Abstract Number: SESS-3537

Supremo

N1-3 no benefit of RT to Axilla (except in T3)

..but it will take time for Oncologists to change!