

Harmony of Quality of Life and Emotional Well-Being: The Impact of Combining Conservative Breast Surgery with Minimal Reconstruction in Breast Cancer Patients

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Introduction: To assess the influence of conservative breast surgery combined with breast reconstruction (CBS-BR) on the overall condition of breast cancer patients, as well as their quality of life (QOL) and levels of depression.

Patients and methods: The study comprised 50 patients categorized into two groups A and B who underwent surgical treatment for breast cancer, utilizing either (MRM) or (CBS-BR) approach. All participants underwent preoperative assessment of their quality of life (QOL) using The QOL Instrument and an evaluation of depression using The Beck Depression Inventory (BDI). Follow-up assessments were conducted at 3 and 6 months postoperatively (PO).

Results: It was observed that all patients experienced a negative preoperative impact of breast cancer on their QOL; however, they demonstrated gradual improvement with significantly higher total scores on the QOL Instrument (QOL-BC) at 3 and 6 months postoperatively compared to their preoperative scores. The removal of cancer had a positive effect on patients' mood, which continued throughout the postoperative period, resulting in significantly lower Beck Depression Inventory (BDI) scores and a reduced frequency of higher depression grades at 3 and 6 months postoperatively compared to their preoperative scores. There was a notable positive and significant correlation between breast cancer and both QOL-BC and BDI scores, as well as a positive and significant correlation between the scores of both questionnaires.

Conclusion: (CBS-BR) appears to be a safe and effective procedure for treating breast cancer, leading to subsequent improvements in quality of life and a reduction in depression symptoms among patients.

Key words: Conservative breast surgery, breast reconstruction, quality of life, Depression.

Introduction

Breast cancer is the most commonly diagnosed cancer and the primary cause of cancer-related fatalities among women worldwide,¹ undergoing a mastectomy often results in a significant degree of depression and anxiety, ranging from moderate to severe. This emotional impact primarily stems from the feelings of imperfection and vulnerability experienced by women after the loss of a part of their bodies.² It has been noted that Patients who undergo mastectomy for breast cancer are more likely to experience depression compared to those without the disease.³ Breast loss from breast cancer surgery increases depression risk in women, with similar rates observed in mastectomy and lumpectomy patients.³ The emotional response following mastectomy comprises two primary components: one related to the sorrow associated with the loss of the breast and the other associated with the anticipated sadness stemming from the potential fatal consequences of the diagnosis.

This underscores the importance of prioritizing psychosocial therapy in the context of breast malignancy, with an emphasis on addressing the psychological impact of the cancer diagnosis itself over the loss of the breast.⁴ The understanding of breast cancer and its treatment has evolved over time, with a notable shift in focus. It appears that the impact of the type of surgery a patient undergoes is influenced more by the patient's perception of physical alteration and shifts in their sexual and emotional dynamics within their marriage, rather than being solely determined by the medical prognosis or physical disability. Additionally, the extent of functional impairment and whether the patient received radiation therapy or chemotherapy did not exert separate or independent effects on the patient's psychological adjustment.⁵ For women, the impact of changes in physical appearance, particularly those resulting from breast cancer surgery, can lead to depression and have a generally detrimental effect on their overall quality of life.⁶

The breast cancer death rate continues to decline in many countries.⁷ Many women will survive breast cancer but may still face physical and psychological consequences that impact their daily life.⁸ Recent advancements in the diagnosis and treatment of breast cancer enable early detection and longer life expectancy, which in turn raises the important consideration of the quality of life for patients with extended survival prospects.⁹ The surgical treatment of breast cancer is rapidly evolving towards less invasive procedures. Breast-conserving surgery (BCS), which was first described in the 1970s and is typically followed by radiotherapy, has been shown to yield results equivalent to mastectomy in terms of outcomes,¹⁰ Breast-conserving treatment is now widely regarded as the primary approach for early-stage breast carcinomas and is currently employed globally,¹¹ Breast-conserving treatment (BCT) has quickly emerged as a significant alternative to mastectomy for early-stage breast cancer. This shift is attributed to its capacity to offer improved cosmetic outcomes while maintaining an equivalent survival rate when compared to modified radical mastectomy (MRM).¹² classically, the endpoints in breast cancer patient assessments include disease-free survival, tumor response, and overall survival,¹³ Nevertheless, it became evident that these endpoints alone did not offer a comprehensive basis for making treatment decisions. As a result, there is an increasing focus on evaluating the well-being and quality of life of individuals with cancer as an integral component of treatment evaluation.¹⁴ Considering that the initial publication of clinical trials that found no significant difference in survival duration between breast-conservative surgery and mastectomy, the dialogue surrounding the physical, psychological, social, occupational, and sexual consequences of various treatment approaches has persisted,^{15,16} Given the equivalent survival outcomes of both surgical procedures, women's individual preferences and considerations related to their quality of life play a significant role in guiding their treatment decisions,¹⁷ While breast-conserving therapy is typically Regarded as the established norm of care for women diagnosed with early-stage breast cancer, some patients may experience suboptimal cosmetic outcomes. These can include breast asymmetry resulting from tumor excision and the progression or formation of fibrotic tissue as a result of exposure to radiation,¹⁸ Breast asymmetry can serve as a continual reminder for these patients of their disease and the treatment they underwent, potentially affecting their psychological adjustment following the completion of treatment.¹⁹ Enhanced cosmetic outcomes can be attained by employing plastic surgery techniques immediately following appropriate oncologic resection, a method commonly referred to as oncoplastic surgery.²⁰

Absolutely, effective communication and comprehensive preoperative planning are vital components of oncoplastic surgery. This collaborative process should engage the mastologist, plastic surgeon, oncologist, and, most importantly, the patient to ensure the best possible outcomes.²¹ Identifying patients who may be at risk for poor aesthetic outcomes following breast-conserving therapy during the initial consultation is crucial. This early recognition is important because oncoplastic techniques can provide these patients with the potential for enhanced long-term quality of life.²² Numerous studies have examined the impact of mastectomy and breast-conserving surgery on quality of life (QoL). While many of these studies have focused on QoL dimensions specific to breast malignancy, such as body image and sexual function, there is relatively less published data on the effects on physical health and overall QoL. The findings from these comparative studies have produced varying results, with some indicating no significant differences in all dimensions of QoL measured between the two management methods,²³⁻²⁵ On the other hand, some of these studies have shown significantly better results in one or more dimensions of quality of life (QoL) for women who undergo breast-conserving surgery.^{5,26,27} Among the various dimensions of quality of life (QoL), body image is the one that has consistently demonstrated better outcomes for women undergoing breast-conserving surgery.^{27,28} Breast cancer management has undergone a significant revolution over the past three decades. With the effectiveness of conservative surgery well-established, research efforts have shifted toward further minimizing the need for surgery and radiotherapy. The primary goal of these endeavors is to enhance cosmetic outcomes and improve the overall quality of life for breast cancer patients.²⁹ Recent advancements in immediate breast reconstruction techniques have demonstrated their ability to deliver favorable cosmetic results while also being established as safe options for breast cancer patients.³⁰ The occurrence of breast cancer carries a significant emotional and social consequences and is regarded as a public health concern.³¹ Anxiety and depression, both of which are highly prevalent psychological disorders among cancer patients, hold significant importance as Factors in studies evaluating the overall well-being, especially individuals with breast cancer.³² In recent years, Progress in plastic surgery methods has led to satisfactory outcomes that align with patients' aesthetic and psychological expectations. These advancements aim to minimize the emotional trauma associated with disfiguring surgical procedures.³³

While there is a general acknowledgment that many

partial breast resections have the potential to be effectively managed through primary closure, it's important to note that the aesthetic outcome can sometimes be unpredictable. A substantial number of women have reported experiencing breast asymmetry following breast-conserving therapy. This can lead to significant contour deformities, ultimately resulting in unsatisfactory aesthetic results and challenges in performing everyday activities.^{19,34}

Hence, the objective of this study was to evaluate the influence of conservative breast surgery with breast reconstruction (CBS-BR) on cancer management, quality of life (QOL), and the psychological well-being of breast cancer patients who have been scheduled for conservative breast surgery.

Hypothesis: The aim of this study is to present the findings regarding the outcomes of concomitant conservative breast surgery with breast reconstruction and its effects on quality of life and depression, in comparison to patients who underwent the conventional modified radical mastectomy.

Setting: University Hospital, Benha, Egypt, many private centers in Benha city, Egypt.

Patients and methods

The current prospective comparative study was carried out at the General Surgery Department of Benha University Hospital from January 2015 to January 2022, with a follow-up period of at least 6 months for the last patient who underwent surgery. Exclusion criteria encompassed patients necessitating preoperative neoadjuvant therapy, those with a history of any prior malignancy, and patients who declined one of the proposed treatment procedures. Following approval of the study protocol and obtaining fully informed written consent from patients, all individuals diagnosed with T1 and T2 breast cancer who were scheduled for surgery were included in the study.

Patients were randomly assigned to two groups based on the surgical procedure: Group A: Comprising 25 patients who underwent surgical treatment in the form of conservative breast surgery with minimal breast reconstruction (CBS-BR). Group B: Consisting of 25 patients who underwent surgical treatment in the form of modified radical mastectomy.

All patients underwent a comprehensive assessment, including a detailed medical history and clinical examination, which involved breast examination to confirm the presence of the mass and its precise location within the breast, as well as its distance from the nipple-areola complex.

Additionally, all patients underwent preoperative mammography, breast ultrasound, and needle

biopsy to confirm the diagnosis, followed by preoperative histopathological examination.

Furthermore, preoperative demographic information was collected from all patients, including Age, body weight, height, body mass index (BMI), tumor stage, and nodal stage, and the type of surgery performed

Operative procedureAll surgeries were performed under general inhalational anesthesia with endotracheal intubation, and the patients were positioned in the supine position. Before the induction of anesthesia, the sites for skin incisions were carefully marked.

Surgical technique

In Group A, which consisted of patients undergoing conservative breast surgery with minimal breast reconstruction (CBS-BR), the procedure involved the removal of the entire breast quadrant containing the carcinoma. The excised tissue was sent for frozen section histopathological examination to ensure that surgical margins were free of cancer. Additionally, axillary clearance was performed, either through a separate incision or by extending the existing incision in some cases, to remove all axillary lymph nodes up to the apex of the axilla. Following these steps, minimal breast reconstruction was carried out.

In Group B, modified radical mastectomy was performed using the traditional method, which entails the Complete excision of the entire breast tissue and axillary clearance while preserving the pectoralis muscles. All excised tissues were sent for histopathological examination.

All patients in both groups completed their prescribed courses of chemotherapy, radiotherapy, and hormonal therapy, as per the treatment plan.

During the study, various parameters were recorded, including operative time, duration of hospital stay, and the occurrence of intraoperative and postoperative complications. All patients received immediate postoperative care.

Furthermore, all patients were assessed for the influence of breast cancer on their quality of life and the possible presence of depression. These evaluations were conducted preoperatively, and both questionnaires were repeated at the 3-month and 6-month post-surgery marks

1. Beck Depression Inventory

The Beck Depression Inventory (BDI) A 21-item assessment scale was used, with scores ranging from 0 to 3 for each item. The raw scores were totaled to calculate a BDI score, which could fall within the range of 0-63. Scores of 1-10 were considered normal mood fluctuations, 11-16

indicated mild mood disturbance, 17-20 indicated borderline clinical depression, 21-30 indicated moderate depression, 31-40 indicated severe depression, and scores above 40 indicated extreme depression. For statistical analysis, a BDI score of ≥ 17 served as the cutoff point to distinguish between women with depression and those without or with only mild mood disturbances. The BDI was administered at discharge and at 3- and 6-month postoperative follow-ups.

2. Quality of Life Instrument - Breast Cancer Patient Version

The Quality of Life Instrument (BREAST CANCER PATIENT VERSION) (QOL-BC) This is a 46-item ordinal scale designed to assess the quality of life in breast cancer patients. Patients are instructed to read each statement and indicate their level of agreement by circling a number on a scale, which ranges from 0 (Indicating the worst outcome) to 10 (Indicating the best outcome). The scale covers four domains of quality of life: physical well-being, psychological well-being, social well-being, and spiritual well-being. Some items have reverse anchors, so scoring involves reversing the scores for those specific items.³⁶ The higher scores in each domain scale represent better health status. (Table 1).

Statistical analysis

Obtained data were presented as mean \pm SEM. Results were analyzed using paired t-test and One-way ANOVA Test. Statistical analysis was conducted using the IBM SPSS (Version 16, 2007) for Windows statistical package. P value < 0.05 was considered statistically significant.

Results

Population characteristics

The current study included 50 patients with cancer breast fulfilling the inclusion criteria, the study included 50 female patients with mean age $53.78 \pm .939$ range (38-67) years and mean body mass index of $29.3826 \pm .43721$; range: (23.66 - 37.46) kg/m². 5 had T1 tumors, while 45 patients had T2 and 3 patients had No nodal involvement, while only 47 patients had N1 nodal involvement. There was non-significant ($p > 0.05$) difference between both study groups as regards enrolment data and disease-related data, (Table 2).

Categorized into two groups

1-Group A (BCS with reconstruction group).

2-Group B (MRM) modified radical mastectomy.

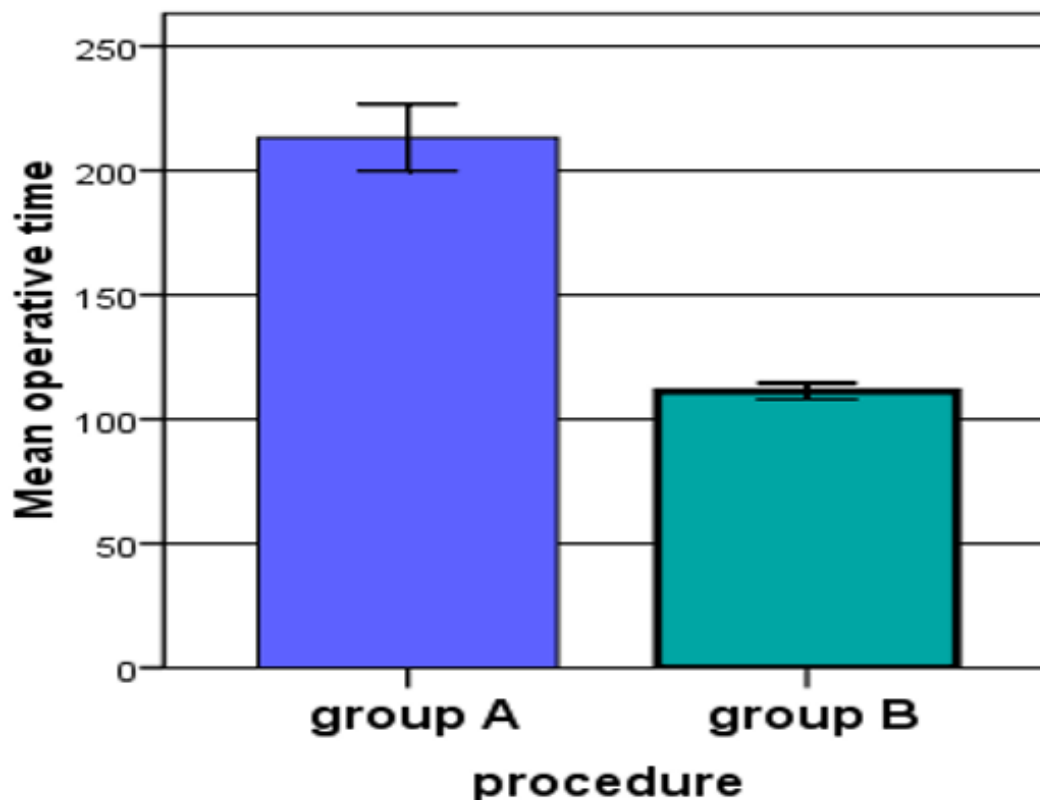


Fig 1: Mean values \pm 2 SE of operative time.

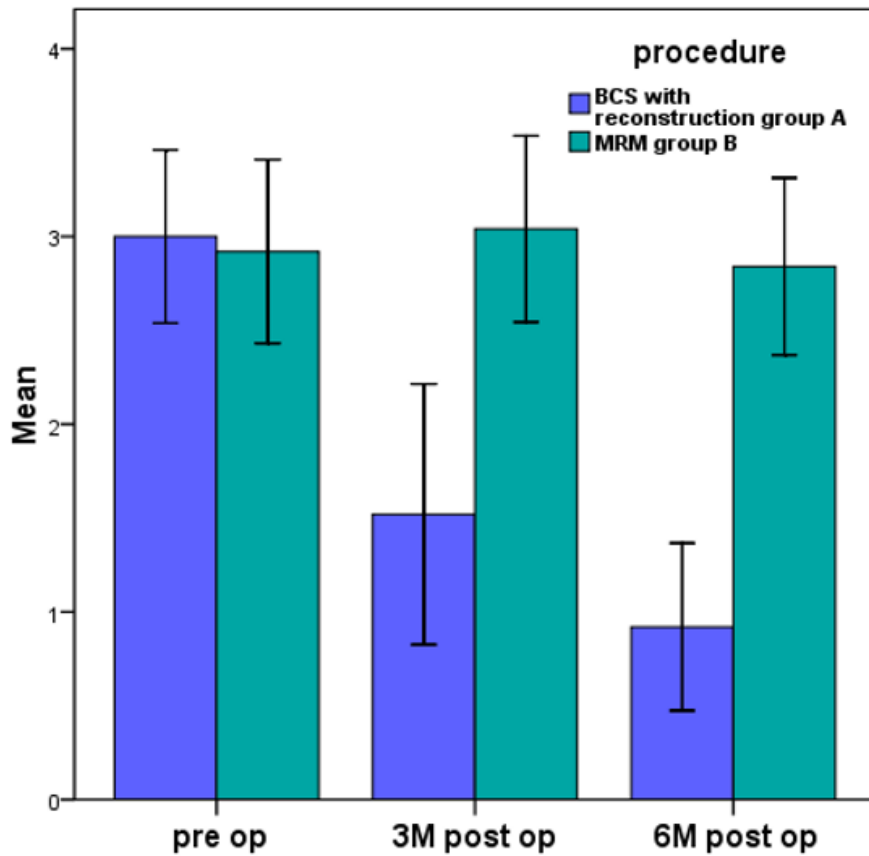


Fig 2: Mean values +/- SE of BDI of both groups pre and 3,6months postoperative.

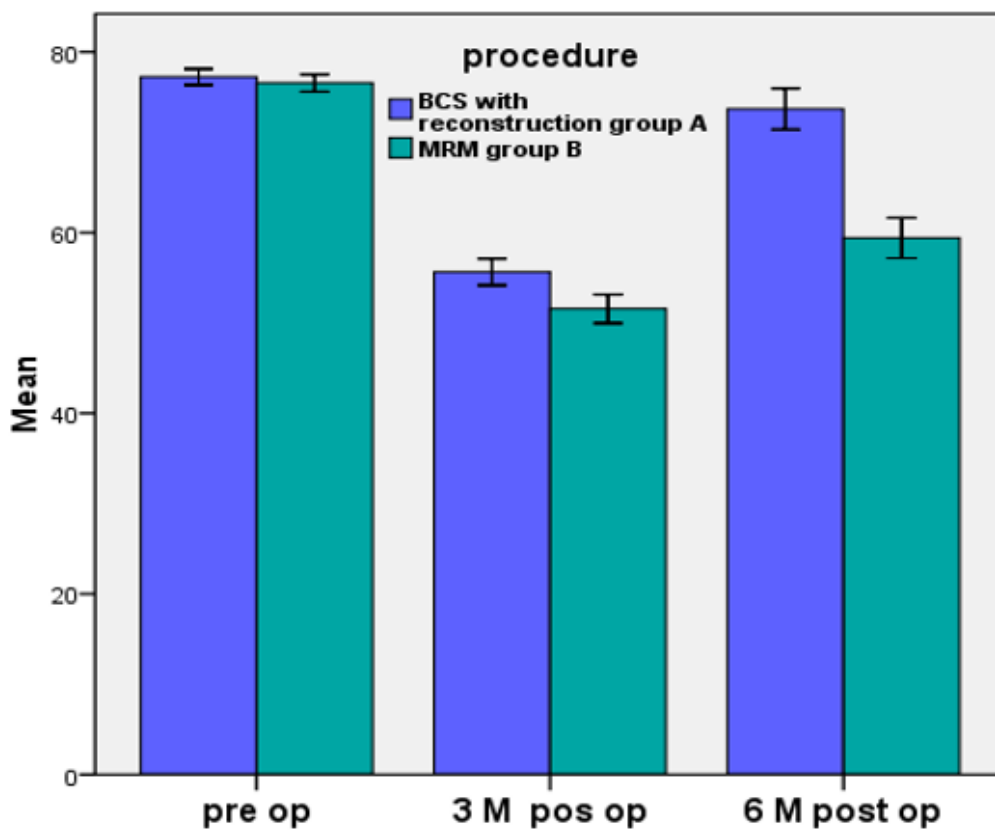


Fig 3: Mean values +/- SE of physical scores of both groups pre and 3,6months postoperative.

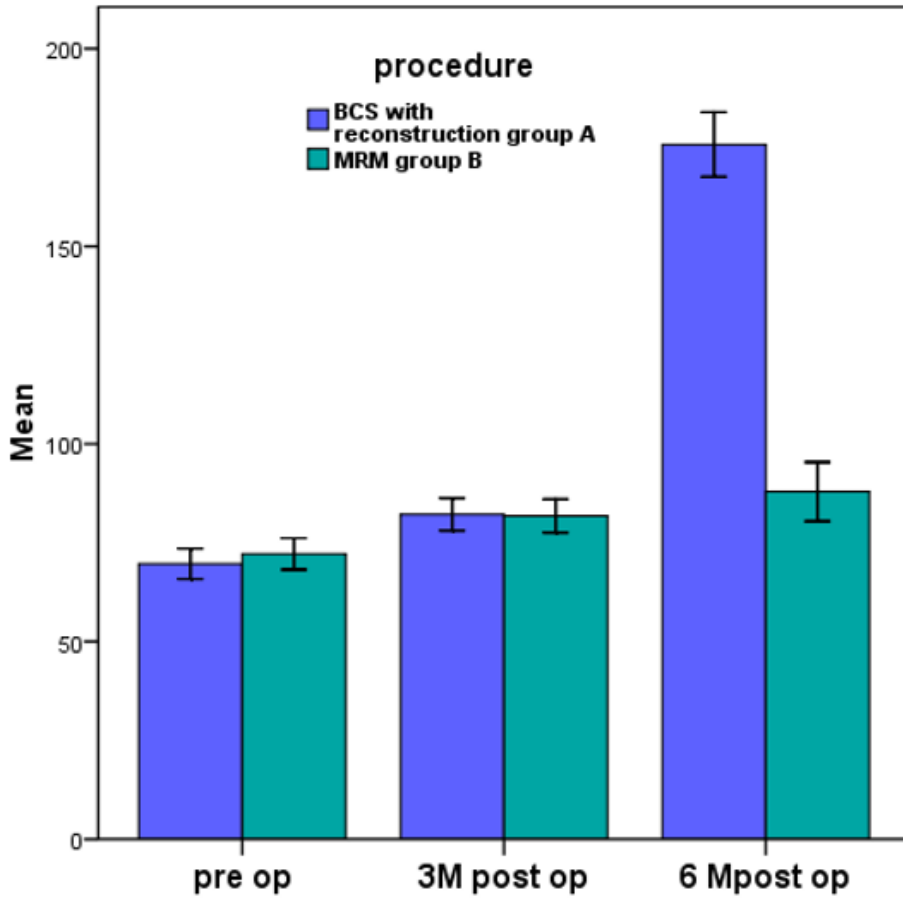


Fig 4: Mean values +/-2 SE of psychological scores of both groups pre and 3,6 months postoperative.

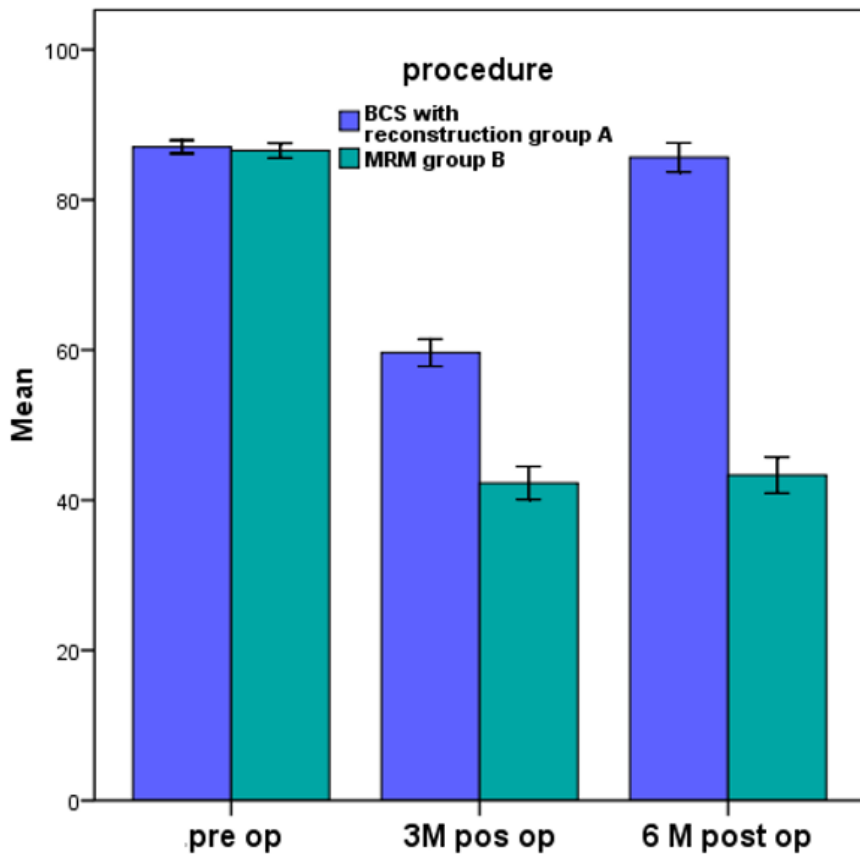


Fig 5: Mean values +/-2 SE of social scores of both groups pre and 3,6months postoperative.

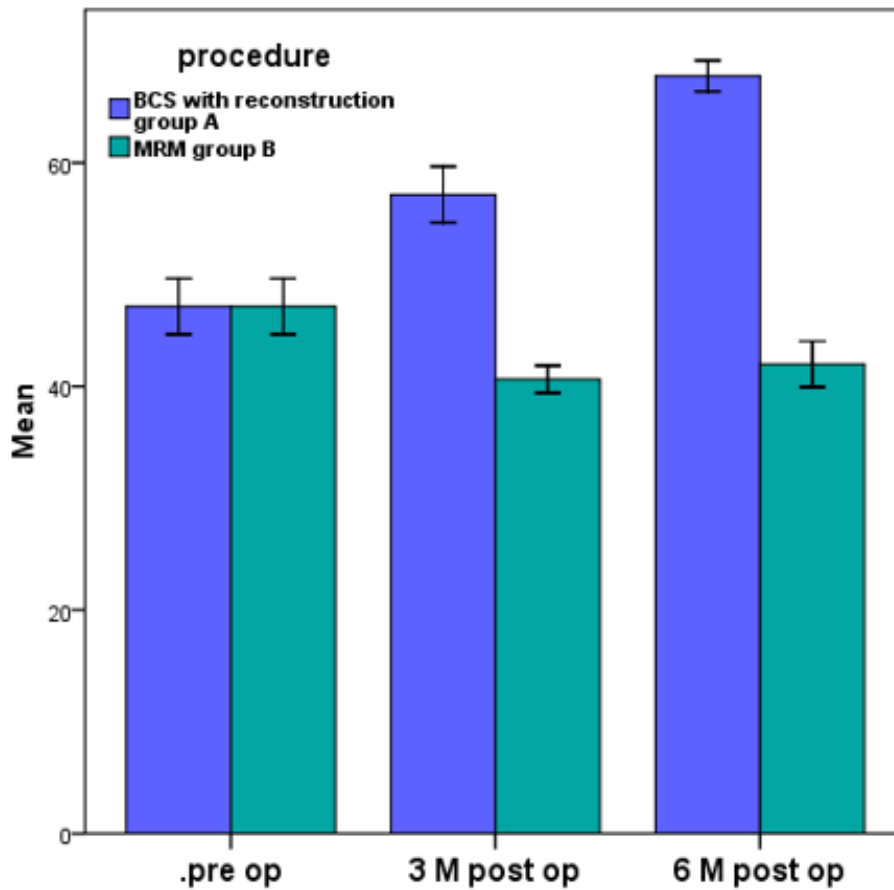


Fig 6: Mean values +/- 2 SE of spiritual scores of both groups pre and 3,6monthes postoperative.

Table 1: Scoring

Quality of life domain	Number of questions	Scoring	
		Per question	Total
physical well being	8	0-10	0-80
Psychological well being	22	0-10	0-220
social well being	9	0-10	0-90
spiritual well being	7	0-10	0-70

Table 2: Patients' enrollment data, n=50

Patterns		MRM group B (Mean± Std. Error Mean)	BCS with reconstruction group A (Mean± SEM)	Total Mean± Std. Error Mean	
Age (years)		54.36±1.16 (40-67)	53.20±1.49 (38-64)	53.78±.93 (38-67)	
Age.Categ	35-40	2 (8%)	1 (4%)	3 (6%)	
	41-50	8 (32%)	5 (20%)	13 (26%)	
	51-65	15 (60%)	18 (72%)	33 (66%)	
	>65	0 (0%)	1 (4%)	1 (2%)	
BMI (kg/m ²)		29.19±.58 (24.16- 37.11)	29.56±.65 (23.66-37.46)	29.38±.43 (23.66 -37.46)	
BMI.CATEG	23-25	1 (4%)	1 (4%)	2 (4%)	
	25-30	13 (52%)	15 (60%)	28 (65%)	
	30-35	10 (40%)	8 (32%)	18 (36%)	
	35-40	1 (4%)	1 (4%)	2 (4%)	
Disease related data	(Tumor stage)	T1	2 (8%)	3 (12%)	5 (10%)
		T2	23 (92%)	22 (88%)	45 (90%)
	(Nodal stage)	N0	2 (8%)	1 (4%)	3 (6%)
		N+	23 (92%)	24 (96%)	47 (94%)

Data are presented as Mean± Std. Error Mean & numbers; ranges & percentages are in parenthesis.

Table 3: Operative and immediate postoperative surgical data

		MRM group B (Mean± Std. Error Mean)	BCS with reconstruction group A (Mean± Std. Error Mean)	Statistical analysis
Operative time (Min)		111.20±1.615 (95-120)	213.28±6.725 (120-260)	p<0.001
Wound related complications	Yes	2 (8%)	1 (4%)	p=0.561
	No	23 (92%)	24 (96%)	
Postoperative hospital stay (days)		2.56±.154 (2-5)	2.36±.114 (2-4)	p=0.301

Data are presented as mean ± Std. Error Mean; ranges are in parenthesis.

Table 4: Preoperative and PO BDI data

Differential scores	MRM group B			BCS with reconstruction group A			P- value
	Pre-op	3-m PO	6-m PO	Pre-op	3-m PO	6-m PO	
Normal (0-10)	0 (0%)	1 (4%)	1 (4%)	0 (0%)	12 (48%)	13 (53%)	Preoperative 0.810
Mild mood change (11-16)	3 (12%)	1 (4%)	1 (4%)	3 (12%)	2 (8%)	4 (16%)	
Borderline clinical depression (17-20)	7 (28%)	6 (24%)	8 (32%)	5 (20%)	3 (12%)	5 (20%)	
Moderate depression (21-30)	7 (28%)	8 (32%)	8 (32%)	8 (32%)	3 (12%)	3 (12%)	
Severe depression (31-40)	5 (20%)	6 (24%)	5 (20%)	7 (28%)	4 (16%)	0 (0%)	<0.001 <0.001
Extreme depression (>40)	3 (12%)	3 (12%)	2 (8%)	2 (8%)	1 (4%)	0 (0%)	

Data are presented as number of cases + percent.

Discussion

The loss of a breast, which holds significant importance for female sexuality, body image, and reproductive identity, disrupts the bio-psycho-social equilibrium. This disruption gives rise to various related challenges and consequently has a profound impact on the quality of life of breast cancer patients.³⁷ The matter remains a subject of debate; however, it's important to highlight that the majority of published studies from the 1980s and early 1990s, such as the work by Schain et al. in 1983, have contributed to this ongoing controversy,³⁸ and Noguchi, M., et 1993,³⁹ These studies from the 1980s, including the work by Schain et al. in 1983, indicated that breast-conserving surgery (BCS) did not provide a safeguard against psychological dysfunction.^{33,40} The absence of psychological benefits associated with breast-conserving surgery (BCS), as suggested by these earlier studies, might have been influenced by concerns about the possibility of cancer recurrence, given that only a small portion of the breast is excised. However, more recent research, such as the study by Li et al. in 2018, may shed new light on this issue,³⁰ and Sanger, C.K. and M. Reznikoff 1981 26 reported no significant difference between the breast-conserving surgery (BCS) group and the mastectomy group concerning concerns about cancer recurrence and psychological morbidity.. Surgical intervention plays a crucial role in the treatment of breast cancer, but it can have a negative impact on various aspects of the patient's life. It often affects body image, self-confidence, psychological well-being, sexual life, and interpersonal relationships in a detrimental manner.⁴¹ Mastectomy, as a surgical treatment for breast cancer, can lead to a range of physical and psychological challenges for patients. These may include pain, depression, anxiety, fear, anger, and other affective disorders, as well as fatigue, diminished sexual desire, decreased self-esteem, withdrawal from social interactions, concerns about femininity, fear of cancer recurrence, difficulties in finding suitable clothing, issues related to breast implants, distorted body image, and challenges in marital and intimate relationships.⁴² Conservative breast surgery with concomitant breast reconstruction has shown to be advantageous compared to modified radical mastectomy in early-stage breast cancer. This advantage is evident through significantly better quality of life, encompassing physical, psychological, social, and spiritual well-being, as well as a lower rate of depression. It's worth noting that both procedures for breast preservation and immediate reconstruction of the breast have been on the rise, but they do require substantial resources and are associated with costs. Therefore, it is essential to assess patient satisfaction with the cosmetic

outcomes and psychological effects of wide local excision and breast reconstruction.

Despite the fact that the operative time for conservative breast surgery is significantly longer than that for modified radical mastectomy, as observed in our study (**Table 3**), these findings align with previous research, such as the study by Veronesi et al.⁴³ which found no significant difference between the two groups in terms of disease-free survival or overall survival.⁴³ Based on these findings, it appears that mastectomy may result in unnecessary deformity in patients with breast cancer tumors smaller than 2 cm and no palpable axillary nodes. Conservative breast surgery with concomitant breast reconstruction seems to offer better outcomes in terms of preserving the patient's physical and psychological well-being in such cases.⁴³ Advancements in breast reconstruction surgery, incorporating new materials and techniques, enable us to achieve optimal cosmetic outcomes for patients without compromising the necessary oncological control of the disease.⁴⁴ Oncoplastic surgery for breast cancer has demonstrated its reliability as a surgical option, effectively addressing both aesthetic and oncologic considerations.⁴⁵ In similar studies comparing BCS and MRM, Han et al.⁴⁶ (2010) .Arndt et al. observed that breast-conserving surgery (BCS) patients exhibited higher physical and mental well-being compared to other surgical approaches.⁴⁷ Bulotiene et al. (2008) reported improved physical and social functioning as well as an enhanced general quality of life in their study.⁴⁸ De Haes, J. C., et al. (1986) found that in the post-breast-conserving surgery (BCS) period, young women exhibited higher role functioning, while retired women demonstrated better social functioning compared to those who underwent modified radical mastectomy (MRM)⁴⁹. De Haes, J. C., et al. found that individuals who received breast-conserving surgery (BCS) exhibited better general well-being, fewer physical symptoms, improved role performance, enhanced emotional state, cognitive state, social state, reduced fatigue, less nausea, decreased dyspnea, improved sleep, reduced anorexia, fewer cases of constipation and diarrhea, and fewer financial problems compared to other treatment options.

In this study, the quality of life was found to be superior in patients who underwent breast-conserving surgery (BCS) when comparing different surgical interventions. This observation was based on assessments using The Quality of Life Instrument (BREAST CANCER PATIENT VERSION) (QOL-BC) (**Figs. 4-7**) and evaluations of depression using The Beck Depression Inventory (BDI) (**Table 4, Fig. 3**). Consistent with findings from other studies, BCS emerged as a positive factor that

positively influenced both functional and symptom scales in both the QOL-BC and BDI assessments. Patients who received BCS displayed a better functional state and experienced fewer symptoms.

Although BCS sometimes posed challenges, such as requiring more than 4 weeks of radiotherapy and being more costly than mastectomy, it yielded superior outcomes in terms of body image, patient satisfaction with cosmetic results, and psychosocial well-being. These differences were statistically significant in this study. Regarding the primary objective of this study, which focused on concomitant conservative breast surgery with breast reconstruction, a significant improvement in quality of life and a reduction in depression were observed when comparing the pre-operative state to the post-operative state. These improvements encompassed physical, psychological, social, and spiritual aspects, as indicated by the four components of the QOL-BC questionnaire: physical, psychological, social, and spiritual group A (BCS with reconstruction group A) group B (MRM group B) physically 3 months (55.64±.739) 51.56±.798) P value (.000), 6 months (73.68±1.134) (59.40±1.112) p value (≤.000), psychologically 3 months (82.16±2.052) (81.76±2.114) p value (.893), 6 months (175.76±4.086) (87.92±3.726) p value (≤.000) , socially 3 months (57.16±1.253) (40.64±.616) p value (≤.000) ,socially 6 months (85.64±.971) (43.32±1.205) p value (≤.000) and spiritually 3 months (57.16±1.253) (40.64±.616) p value (≤.000) 6 months (67.76±.696) (42.00±1.026) p value (≤.000) of both groups respectively. These results compared to the pre operative deterioration of PO QOL evaluated by PO Quality of Life Instrument (BREAST CANCER PATIENT VERSION) (QOL-BC) scoring that was manifested as significantly higher frequency of patients had PO good QOL comparison to preoperative scoring with decreased frequency of patients had bad QOL after surgery physical pre operative (77.24±.448) (76.56±.473) p value (.302) psychological pre operative (69.68±1.924) (72.16±1.996) p value (.376) social pre operative (87.04±.442) (86.56±.497) p value (.474) spiritual pre operative (47.16±1.253) (47.16±1.253) p value (1.000).

These findings support earlier research by Al-Ghazal et al. (1999), which found that patients with superior cosmesis had better psychological outcomes' has long been a goal of surgeons and radiotherapists, and it is now recognized as a suitable therapy,^{12,43} for the treatment of primary breast cancer. Early comparisons of BCS with mastectomy did not show any significant psychological advantages, according to Al-Ghazal et al. However, more recently, following extensive local excision, documented cosmetic results and patient satisfaction in distinct reports,

S.K. Al-Ghazal 1999 It has been demonstrated that stronger cosmesis fosters greater psychological well-being.⁴⁰ The patients who underwent breast reconstruction recalled less psychological distress than those who underwent simple mastectomy without reconstruction, which further supported our findings that breast reconstruction offers another option with potential psychological benefits to patients with operable breast cancer. Our findings support a prior study by Monteiro-Grillo et al. from 2005³², which hypothesized that postmastectomy breast reconstruction had favorable impacts on sexual life. Additionally, our study's examination of depression using The Beck Depression Inventory (BDI) revealed improved mood and a lower number of patients with depression in group A who underwent BCS with concurrent reconstruction, as shown in **(Table 4)** as before, in line with earlier research by Al-Ghazal, S.K. 1999, which demonstrated that the final cosmetic outcome has a significant impact on the development of the psychological outcome. Comparing patients receiving BCT to those undergoing mastectomy or reconstructive surgery, Han, J., et al. (2010) found that patients with BCT have a greater satisfaction rate with their postoperative breasts and a better quality of life. (2008) Arndt, V., et al. In time after treatment is over, some relatively specific benefits of BCS, like a more positive body image, are already apparent. However, benefits in broader measures, like psychosocial well-being.

Being and general quality of life steadily improve with time and only fully manifest themselves over time.

Conclusion

Prioritizing the psychological well-being and quality of life of breast cancer patients is a crucial objective in their management. This study has led us to conclude that patients who undergo breast-conserving surgery with concomitant breast reconstruction may benefit from reconstructive consultation compared to those undergoing mastectomy alone. This approach can contribute to improved overall outcomes and enhanced patient satisfaction in the context of breast cancer treatment.

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