

*Letter to the editor*

**In response to 'Mastectomy under Local Anesthesia in Locally Advanced Breast Cancer in an Unfit Patient'**

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To the editor,

We read with interest the article 'Mastectomy under Local Anesthesia in Locally Advanced Breast Cancer in an Unfit Patient' by Irshad et al (1). We have made the following observations based on our institutional experience (2) and evidence-based contemporary medical literature.

The authors have described the use of local anesthesia for a toilet mastectomy in a middle-aged lady with locally advanced breast carcinoma. While the clinical decision on opting for toilet mastectomy in view of relieving the patient of the pain and cosmetic distress by removing the fungating mass, reducing the potential seeding of the tumor and distant metastasis, and, improving the immunocompetence by reducing the tumor bulk is justified (3), we respectfully would like the authors to clarify the following points.

1. The authors have indicated the ultimate reason for the deferral of general anaesthesia as a 2-week 'cough'. No details pertaining to the examination of the chest, inflammatory markers, whether pulmonology or general medical opinion was sought, and the specific/ supportive treatment are given in the manuscript, which would have justified the reason for opting for local anaesthesia in preference. The x-ray and computed tomography of the chest did not reveal any abnormalities including metastasis, which might have revealed the aetiology for the persistent cough. Exclusion of her COVID-19 would have been appropriate and timely considering the prevailing pandemic and a 2d-echocardiogram might have yielded a cardiac cause for her symptomatology.
2. Apart from local and general anaesthesia,

numerous anaesthetic modes have been discussed and practiced for mastectomy with excellent results, in the aspects of satisfactory, lengthy intraoperative and postoperative analgesia and additional benefits (related to each technique). These are feasible options in patients deemed unfit for general anaesthesia provided absolute contraindications are excluded. Thoracic epidural, thoracic paravertebral (single-level or multilevel), pectoralis 1 and 2 blocks, and intrapleural blocks are all frequently utilized anaesthetic techniques. The incorporation of ultrasound has further increased the safety profile and success rates of these anaesthetic techniques. Epidural and perineural catheter techniques have further extended the duration of postoperative analgesia, resulting in increased patient comfort and acceptance by both the clinicians and the patients. Pec 1 and 2 blocks might not have been practical in this patient due to the larger tumor. If the patient did not have respiratory distress and her clotting profile was unaltered, the rest of the techniques could have been utilized safely.

3. The description of the conduct of local anaesthesia in the case description is at best incomplete; which is basically the highlight of the case report. The doses utilized, the method adopted during local anaesthetic administration, whether the short-acting local anaesthetic (xylocaine 1%) satisfactorily covered the duration of surgery, the reason for not choosing a longer-acting local anaesthetic such as levo/bupivacaine, monitoring during surgery and afterward (specifically, for respiratory depression following nalbuphine administration and for local anaesthetic systemic toxicity) could have been discussed in detail. It

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is imperative that dose reductions are required for local anaesthetics in patients with organ dysfunction (not relevant to this patient).

4. There is evidence that local anaesthesia and regional nerve blocks such as the paravertebral block lead to reduced recurrence of primary breast carcinoma (4). Several theories have been postulated which include reduced stress response to surgery, avoidance of immunosuppressant effects of morphine and general anaesthesia, and modulating voltage-gated ion channel expression of the cancer cells (5). A brief discussion on this aspect could have been more informative rather than a discussion on routine surgical follow-up

of the patient.

It is our intent to create a conducive yet constructive discussion on the matter rather than a bland criticism. Similarly, we would like to acknowledge the team of authors for their attempt at publishing their experience and most importantly successfully managing the patient.

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