Race and breast cancer reconstruction: Is there a health care disparity? Is there indeed. Sharma and colleagues explore this important, provocative, complex, and oft-discussed topic in their interesting publication, based on a large experience at a university medical center.1

The authors offer a variable-controlled (adjusted for clinical, pathologic, and socioeconomic variables) investigation of racial disparities concerning autologous versus expander/implant-based breast reconstruction rates. They are commended for their effort.

Not surprisingly, Sharma et al. found, as have others the authors reference, that African American women, when compared with white women, were more likely to be underinsured and have more preoperative comorbidities. Reviewing the National Inpatient Sample from 2002 through 2006, Shippee et al. evaluated the relationship among primary payer, race/ethnicity cohort, and breast reconstruction rates among women who underwent mastectomies. Controlling for patient comorbidities, they found that minority women (including, but not exclusively African Americans) had a lower breast reconstruction rate than white women. They concluded that health insurance facilitates access to postmastectomy care, but did not eliminate racial/ethnic disparities in reconstruction rates.2

Interestingly, as referenced by Sharma and colleagues, Enewold et al. found in their 1998 to 2007 study of U.S. Department of Defense (Tricare health maintenance organization) beneficiaries that, when equal access to health care is available, breast reconstruction rates did not vary significantly, irrespective of race or ethnicity. They suggest that the racial disparities observed in many studies are at least in part attributable to variations in health care access.3

The finding by Sharma et al. that African American race was the most significant predictor, after controlling for multiple variables, for choice of autologous tissue as the breast reconstruction method is somewhat surprising and perhaps counterintuitive. One might reasonably expect that autologous tissue reconstruction rates would actually be lower in a patient cohort with an above average incidence of diabetes mellitus, tobacco use, obesity, and underinsurance.

The authors briefly postulate that concomitant abdominal panniculectomy, as a consequence of abdominal pannus use for breast reconstruction, may have been a significant motivating factor in the African American cohort, and may thus in part explain the autologous tissue preference observed. This may indeed be true but requires validation. The presence/absence of an abdominal pannus was not elucidated in their study. Furthermore, although the obesity rate was higher for African American women (although, as the authors acknowledge, it was likely undercaptured for all groups), obesity does not necessarily indicate the presence of an abdominal pannus. Again, further evaluation is needed.

In a recent publication, Butler et al. reported their 2005 to 2011 experience using autologous free tissue postmastectomy reconstruction methods for African American women. Preoperative risk factors and postoperative morbidity and mortality rates were assessed with respect to patient race. They found that despite higher risk factor incidence, African American women did not differ significantly from other women in outcomes observed.4

As eliminating health care disparities is a goal of current health care reform initiatives, this report supports the experience of Sharma and colleagues that autologous tissue reconstruction,

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at least when performed by experienced plastic surgeons in high-volume centers, is a safe, reasonable, and perhaps preferable reconstruction option for African American women choosing mastectomy for breast cancer treatment.1,4 I support the authors’ assertion that further research regarding race-related health care disparities is necessary.

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