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Having had the honour and the pleasure of working with Emmanuel van der Schueren and of assisting him as his secretary general when he was president of European Organisation for Research and Treatment of Cancer (EORTC) and president of the European Society of Mastology (EUSOMA), it gives me even more pleasure to be here today and to share with you what I believe I have learnt in more than 30 years of research and clinical practice in the field of breast cancer.

Being a surgeon, I probably feel more comfortable than any other colleague in this room in saying that the first message which comes from the past and tells us something important about the future is that breast-cancer management is not (only) breast-cancer surgery. Women who are still treated in centres where doctors believe that the cure for breast cancer is mastectomy are really unlucky, not only because they miss the opportunity to preserve a comfortable body image, but mostly because they miss the benefit of the multidisciplinary treatment of their disease.

In the past we thought of cancer as an external entity coming to invade our bodies, and medicine's answer was to 'destroy'. To destroy with surgery, with radiotherapy and with chemotherapy. To destroy the tumour, mostly, nearly ignoring the rest of the patient's body and mind. Now we have learnt that what we have to do is gently to reduce the tumour presence, to oppose its growth, antagonise its proliferation, and induce the apoptosis of its cells, from the maximum tolerated action to the minimum effective one. I believe that surgeons have played an important role in this cultural revolution (1).

In the past we were also absolutely convinced that the maxim ‘the earlier the better’ was undeniable, and we have sometimes promoted breast-cancer screening like a religion (despite the fact that most of us are definitively non-religion-oriented). Anti-screening scientists and researchers have also reacted against this approach, sometimes with excessive furore, generating unnecessary antibodies and preventing an objective analysis of the facts and figures. I believe we should in the future continue to seek for an early detection of breast cancer, but we cannot ignore the fact that screening might not actually reduce mortality in certain conditions, as for example in the incidence of advanced breast cancers (2)

How about technology? Is technology always good by definition, as we tended to believe in the past? Probably not. Those who belong to my generation may remember the disappointment at the failure of thermography as a safe, non-x-ray method for diagnosing breast cancer. And those belonging to the current generation are witnessing the downsides of indiscriminate use of MRI: since only 25% of positive findings by magnetic resonance imaging (MRI) represent malignancy, surgical planning should not be routinely based on this exam (3) if we do not wish to go back to the past and to justify ‘the current resurgence in mastectomy’ (4)

How about biology? Is it still relevant to debate whether breast cancer is a local or a systemic disease? Since scientific evidence has proved the efficacy of postoperative radiation therapy after breast-conserving surgery and of adjuvant medical treatment, ‘the era in which surgery was the sole treatment for primary breast cancer [has] come to an end’ (4). Pathology reports were once a few lines long, now they often need more than a page. The possible combinations of the various parameters (grading, lymph-node status, hormonal receptors, vascular invasion, size, Her2 test, etc) are so many that no patient actually has the same disease as her roommate, and doctors and nurses have to make constant efforts to personalise their communication and treatment plans.

Classifications which have been important in the past, such as the tumour-node-metastasis (TNM) system, are becoming less and less meaningful because they are too rigid, and we have learnt that rigidity does not pay. Who would still decide the surgical operation on the basis of the T without also taking into consideration the size of the breast? The old dogma was always mastectomy for any tumour larger than 2.5 cm. Now we have finally become capable of evaluating the tumour/breast size ratio and performing conservative surgery even for a 3-cm tumour if the breast size of the patient allows it, while we find it more appropriate to perform a nipple-sparing subcutaneous mastectomy for a 1.5-cm tumour in a small breast.

Still, what is probably most important in what the past is telling us about the future is that breast-cancer management must involve teamwork. The omniscient and omnipotent super-surgeon who alone can save the life of the frightened and lost breast-cancer patient belongs to the past and should soon disappear worldwide.

The lesson of the past is that the breast-cancer patient of the future will have to be a well-oriented woman, supported by her family and friends (extensively navigating on the internet), informed about the existence of organised patient advocacy groups, diagnosed through a personalised screening programme in which the frequency of mammography was based on her individual risk assessment, exposed to the conclusions of a preoperative multidisciplinary meeting (MDM) of the breast unit of her choice, sufficiently empowered to go through hospitalisation and primary treatment without experiencing desperation and terror, ready to participate in the discussion on proposed postsurgical adjuvant treatments, supported by an experienced dedicated breast nurse, and able to return to her home without feeling abandoned and actually feeling strong enough to go back to normal life.

Women will not miss the surgeon wizard of the past and will appreciate more and more the importance of having well-established and well-organised breast units whose quality is constantly checked and assessed (the battle of Emmanuel van der Schueren's life!) and whose multidisciplinary and multi-professional approach will make the care of all patients fully adequate, up-to-date and patient-centred.

I believe it was Saint Francis who said that a worker is the person who works with his/her hands (the breast surgeon of the past), an artisan is the one who works with hands and mind (the breast radiation and medical oncologist of the past), an artist is the individual who works with his/her own hands, the mind and the heart (the modern breast unit!).

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