

Women's Breasts Are Not to Be Trifled With

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Received: 26 May 2026; **Accepted:** 29 Jun 2026; **Published:** 07 Jul 2026

Citation: Bretz P, Mantik D, Lynch R, et al. Women's Breasts Are Not to Be Trifled With. Japanese J Med Res. 2026; 4(3): 1-7.

ABSTRACT

Here is the Google AI definition of 'trifled with'. "Trifled with" means to have treated someone or something carelessly, lightly, or without the seriousness they deserve, often involving toying with emotions, exploiting trust, or showing disrespect, implying the person or situation is more serious than handled. It suggests playing with feelings, manipulating, or underestimating something important, like someone's affections or a dangerous situation, with consequences for being irresponsible".

What does that have to do with women's breasts? EVERYTHING. Going back to Hippocrates who mentions using a hot poker for breast tumors, it was Leonides of Alexandria who followed Galen (AD180) that perfected the use of a hot poker to destroy breast cancers. Nothing is mentioned about the psychological and lasting physical distortion of the breasts using that technique. In more recent times it was Dr. Benjamin Rush who recommended a mastectomy for John Adam's daughter. His colleague, Dr. John Warren, actually performed the mastectomy in the bedroom without anesthesia, as we know it, in 1811. Further into the future, we find Dr. William Halsted performing his first radical mastectomy, probably at Roosevelt Hospital in 1882. Again, no mention of the unending futility and horrendous psychological effects of this surgery.

Then along comes Dr. Geoffrey Keynes who, in 1937, inserted radium needles into cancer and saw it shrink. He thought that women need not always undergo devastating mastectomy. But it wasn't until 1981 that Dr. Umberto Veronesi, who founded the Istituto Europeo di Oncologia in Milan, Italy, published his seminal paper on lumpectomy and radiation equaling the results of mastectomy. Moving into the 21 Century (2026) surgeons, based on results of IORT (intraoperative radiation therapy), introduced cryoablation using a liquid nitrogen probe to kill cancer. This evokes the strong possibility of successfully avoiding surgery, chemotherapy, and radiation.

To be fair, earlier needs for aggressive surgery were necessary because chemotherapy was either non-existent or in its infancy, and radiation consisted of cobalt with its side effects of fractured ribs, lung injury, and pericarditis. What this paper will decree is for surgeons, who are still in the dinosaur age of necessitating surgery, to either step up to the plate and become proficient in cryoablation or, if necessary, educate themselves in performing a 'cosmetic lumpectomy', or stop doing breast surgery altogether. The scars you leave are permanent.

Keywords

Cryoablation, genetics, Infrared, Flagship breast center.

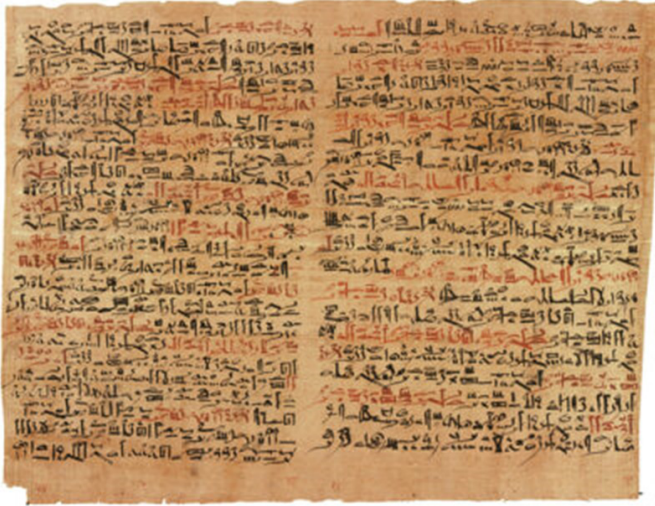
Background

Before recorded history, archeological findings have uncovered a 1.7 million year old aggressive osteosarcoma in a human foot bone. Proving dinosaurs had cancer, a 77 million year old Centrosaurus had in its fibula another osteosarcoma. [1] This paper will just deal with breast cancer from its earliest recorded history until the 21st Century (2026).

The Edwin Smith Papyrus circa 1600 BCE recorded the first

acknowledgement of breast cancer dating from the Old Kingdom and said there was no treatment. The papyrus does however, mention the use of a 'fire-drill' but it was ineffective. And while Hippocrates (460-377 BCE) briefly talked about breast cancer as being caused by black bile, he didn't advocate surgery. Hippocrates coined the word karkinos (crab).

The papyrus is actually located in the New York Academy of Medicina and is about 15 feet long. Imhotep probably wrote the above. It wasn't until Galen (Claudius Galenus) recorded using a hot poker to treat breast cancer that we had some attempt at meaningful intervention.



The above is Egyptian writing about breast cancer [2].

It was left to Leonides of Alexandria (2nd century AD), who probably was the first to remove the entire breast and use cautery irons (sideria) to actually provide an attempt at meaningful treatment. Leonides was the first to not only remove the breast but surrounding tissue around it, then use the hot poker to stem the bleeding and provide further treatment. Moving ahead to the Chinese: The earliest Chinese medical writings about breast cancer appeared in *Urgent Therapeutic Prescription for Axilla Diseases* (肘后急方), which was published in AD 375. This medical book was written by famous Chinese Taoist and Doctor Hong Ge (葛洪, 281–341) during the East Jin dynasty (东晋, 317–420). In volume five of this book, he described breast cancer as “a lump, hard as a stone, with a form resembling a nucleon of drupe or a walnut [3].

In more recent times 1811, we note Dr. Benjamin Rush recommending a mastectomy on John Adam’s daughter. The surgery was carried out in their bedroom by Dr. John Warren with little anesthesia if any, the family held her down. A quote from the letter to Abigail “Nabby” Adams from Rush is, “Let there be no delay in flying to the knife” [4] Fast forward 71 years, we have Dr. William Stewart Halsted performing his first radical mastectomy at Roosevelt Hospital with the patient under ether anesthesia. In these radical surgeries, the overall theory was that breast cancer started in one place and got bigger and bigger and eventually traveled to the first lymph node, then the second and so forth. If there were three lymph nodes involved, if the surgeon could get to the fifth node with a normal one in-between, then they had ‘gotten it all’. It’s what we call ‘The did you get it all’ generation. Even in 1979 in our senior surgeon’s surgical residency, that was usually the second question the family had besides, “Is she ok”. “Did you get all the cancer Doc?” Our answer was always, “yes”. That was true for the cancer we could see. Our senior surgeon says it was like he was participating in a holocaust on women.

The modern era of ‘lumpectomy’, as we know it, really commenced with the publication by Dr. Umberto Veronesi in 1981 in the New England Journal of Medicine. He founded the Istituto Europeo di

Oncologia. The paper was entitled, “Milan I Trial: Quadrantectomy plus Axillary Dissection plus Radiotherapy (QUART) versus Halsted Mastectomy” [5].

Things remained much the same for the fledging ‘lumpectomy’ for many years. However, in about 2002 targeted radiation made its entrance (that a surgeon could participate in), in the form of “MammoSite”. It was termed, “Accelerated Partial Breast Radiation”. We have published in ASTRO our results of surmounting the problem of skin spacing in accelerated partial breast radiation [6]. In an attempt to obtain ‘clear margins’, the surgeon may at times come close to the undersurface of the skin (less than a centimeter) making utilization of MammoSite impossible. During the Vietnam war, we participated in a clinical trial at Hines Veterans Hospital of sampling a piece of abdominal wall fat about the size of an Oreo cookie for traces of ‘Dioxin’, (Agent Orange). In APBR we surmised that if in attempting to get clear margins that resulted in less than one centimeter, we could suture a fat patch as a buttress enabling women to have APBR. We even came to utilize the ‘fat patch’ on locally recurrent breast cancers. To our knowledge, more than 20 years later we have seen one recurrence in those 45 some cases. MammoSite, while not a quantum leap, was a huge advance in the patient receiving only five days of radiation twice daily, then the catheter was removed. This was instead of receiving a full course of external beam radiation five days a week for six weeks with a booster at the end. Below is a typical use of APBR.



The balloon on the catheter should abut the margins of the lumpectomy site 360 degrees.

This is because the rationale for APBR is that 90% of the local recurrences are within 1 centimeter of the lumpectomy margin and that 1 centimeter is sterilized with the targeted radiation. Note, the incision is circumareolar with no indenting of the skin.

The next advance in surgery was the advent of IORT (intraoperative radiation therapy). Now for decades we were told that you must include external beam radiation (six weeks) to kill the cancer that you couldn’t see (occult), otherwise the patient would have

a recurrence. Included with external beam was the shrinking of the breast along with the peau d' orange skin. It still carried the potential of pericarditis, pneumonitis, and totally killing the skin with a black eschar (seen once). IORT now offers just 20 minutes of intraoperative radiation so that when the patient wakes up in recovery, she is done with surgery and done with radiation. It made APBR and external beam radiation almost obsolete except for select cases. The procedure of IORT was carried out with a machine that had an arm with a ball (of different sizes) that represented the radiation source. It was lowered into the lumpectomy cavity and just like APBR, the ball should have abutted the margins of the lumpectomy site. This was a quantum leap with the patient not having to undergo six weeks of external beam radiation. Like almost everything else in cancer technology, IORT was only offered in a few facilities and thus slow to catch on. When hospitals had invested seven figures in a linear accelerator, how anxious do you think they would be to almost abandon that for IORT? The results in the right hands yielded the same results as external beam and APBR.

Having seen the results of IORT caused us to totally rethink our approach to how we could beat breast cancer with little intervention. It logically seemed that every advance in breast cancer treatment from lumpectomy vs mastectomy to APBR and IORT vs external beam yielded the same result or arguably better since they were less invasive and less disfiguring. Dr. Kenneth P. Ramming (RIP) was a noted surgical oncologist and pioneer in using cryoablation to kill liver, pancreatic and prostate cancers. While his technique didn't increase longevity, it made quality of life better just because it was very much less invasive. Instead of resecting a good portion of a patient's liver, he simply inserted the cryo probe into the tumor like a shish kebab and killed the cancer using argon gas. When a large portion of a patient's liver is resected, they have profuse bleeding, and usually a prolonged post-op course of recovery. So, there was good reason to exercise the option of cryoablation. Our senior surgeon had referred patients to Dr. Ramming and with the advent of IORT, the light bulb went off.

METHOD - HOW WE PRESERVED MIND, BODY, AND SPIRIT

Our story begins in 1988 when our senior surgeon founded the first comprehensive breast center in the Coachella Valley, the Desert Breast Institute. From day one we began to see 25-30 patients per day for mammography, ultrasound, and surgery. Those patients would have normally gone to the 30-million-dollar hospital basically on the same campus. But no, there was something we were offering that struck a nerve with the women in the valley and eventually around the world. That something started with the phone call. There was no 'phone tree' as some people call it at DBI. You talked to a live person immediately who was trained to be engaging and helpful. Another something in part was our personal credo striving to preserve mind, body, and spirit of every woman who came through our door, and they knew it. Let's start a list of things that differentiated DBI from say the atmosphere of the hospital. (A) Starting with the location, it was selected because it was a park-like setting, very non-threatening. There was easy

and close parking right outside. There wasn't an aura of sickness as one might expect to be exposed to in the hospital. (B) Our credo extended to the fact that if we had to perform surgery, the goal was to have their breast look like we weren't there ten days or ten years after surgery. That was the goal and the patients knew it. It took a while to realize just how frightening that surgery was for our patients, but we learned quickly. Thus, (C) our senior surgeon made sure he was there when they were transferred from the gurney to the OR bed and he held their hand until they were asleep. Many times, that was the only thing they remembered about the surgery. Our senior surgeon taught himself how to do a 'cosmetic lumpectomy/biopsy'. That is, (D) he abandoned putting an incision on the breast skin itself in favor of a circumareolar incision. The areola is made of erectile tissue, so it hides an incision well.

All that is required after the incision is made is to use the cautery to burn straight down for about a centimeter or so and then, using the cautery and retractors like an Army/Navy or ribbon to tunnel over to the tumor. This creates a supportive wall, so the final result is not as is seen below where the surgeon just ellipsed out the tumor leaving a huge divot. The patient would have to live with that the rest of her life and she was not pleased. Both the patient and her husband went to bed that night thankfully the surgeon was just going to do a lumpectomy. She was grateful her breast would be preserved, then she woke up to the disaster seen here. We understand the pressures of a busy general surgeon who may be up all night from an ER trauma case, then having 4 major cases that day. In our caring for over 14,000 women from all over the globe for 30 years, it didn't take us long to refigure our approach to them. That is, (E) it's totally about them and making this process of breast exam, mammography, and possible surgery as palatable as possible. The key was to 'humanize' the process. We can say now that with Lavender (F), we saw the dramatic positive psychological change in all our patients as they had to deal with cancer. The reader is encouraged to visit our website at thelavenderproject.net and scroll down to see some of the videos. One picture is worth a thousand words.

Below is the image of the ever-lasting huge divot in the breast that should not have happened. If you're going to perform breast surgery, one needs to be skilled enough and care enough not to let this happen.



Having now seen what befell the above patient, below is a cosmetic lumpectomy. See if you can find the incision.

If you're having a hard time, it's in the right breast circumareolar between about 3 o'clock and 6 o'clock. These two images remind us of a story of a patient who came to us for a second opinion about a recommended open biopsy. She was shown several images of how we did it and some of the results of other surgeons in the community. She left wanting a circumareolar incision. When she talked to her HMO surgeon, he said he was 'too busy'. See the disconnect? Let's return to what we tried to do, not just to have patients come in but to have them happy to return year after year.

(G) We were also the first to bring to the valley NCI sponsored clinical trials having joined groups like the N.S.A.B.P. (National Surgical Adjuvant Breast Project, the largest research group in the country), and the American College of Surgeons Oncology Group. In those days (early nineties) we were on the chemotherapy band wagon, then pioneering trials like B-18. That was the first trial to initiate neoadjuvant chemotherapy before surgery. Our reception area was laid out like a well-appointed living room, so it looked to the patient like she was visiting a friend instead of a sterile hospital setting. When a patient takes time to write you a note, you know you're hitting the right cord.



Further, while it's nice to create an inviting living room like entrance, it's really what the patient gets out of it that rules the day and determines what they tell their friends and neighbors. That overtime with many patients creates a reputation in the community (good or bad) and beyond. Below is typical of the non-solicited handwritten notes we received on a regular basis. This note is just one and not put in here to gloat or be self-aggrandizing.

The question for any surgeon out there is how many of these handwritten notes do you receive from patients which take time to do and are not just Hallmark cards? Again, these letters are just put here to illustrate what was confirmed to us, that women respond differently when they know they can depend on you being there for them no matter what. Like same day appointments (H). This is much different than seeing a different doctor (if the patient is

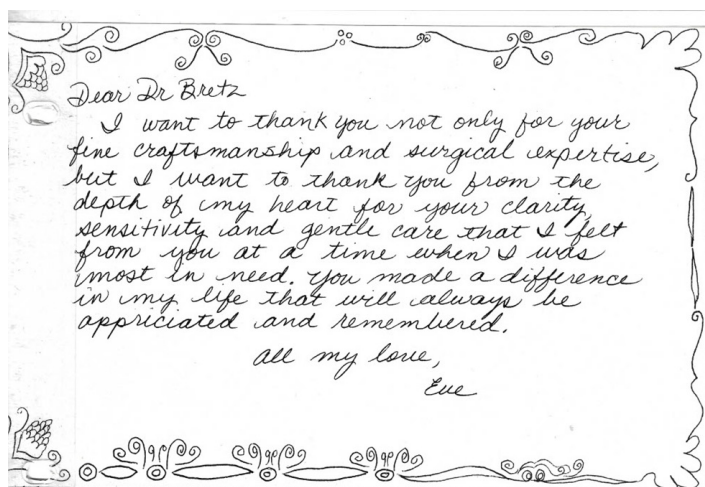
lucky, they see an actual doctor) and not a PA or NP each time they come in for an exam. Caring for women in a way they respond to is not like changing a tire with a different doctor they see every time. The (I) idea (as old-fashioned as it is) was to have the patient see the same doctor every time, and not only that. That same doctor can not only do what is necessary like a proper breast exam and ultrasound, etc, but that doctor would be the same one to discuss options if a cancer was found and the same one who would carry out the treatment, which now is cryoablation. A bond would form.

Desert Hot Springs, CA
May 12, 1989

Dear Dr. Welsh,

At last, someone has figured out a way of making Mammography a pleasant experience. When I walked in to the "Desert Breast Institute" I couldn't believe my eyes: the huge elegantly furnished waiting room, the candy, the coffee and the young, attractive, and friendly staff. The radiologist was gentle. I appreciated seeing and hearing the tape and having the doctor showing and explaining my own films. It should be easy to return for checkups.

Gratefully, Edith E. Chrisman



(J) We had it set up so her breast doctor would immediately discuss with the radiologist her mammogram and then films were discussed with the patient who is encouraged to ask questions so there is a thorough understanding before she leaves (no anxiety waiting for results). In fact, if something like aspiration of a cyst is called for, it is done right then and there. There is no waiting for a referral back to do an aspiration or anything else. If something

more complicated like cryoablation is called for, they get to speak to former patients (if they desire) and see videos so there are no surprises. We intentionally created an atmosphere of *humanization* to the entire process of cryoablation. Let's continue now with how we came to embrace cryoablation, aka The Lavender Procedure.

The question was if targeted radiation of only 20 minutes (IORT) was having the same results as six weeks of external beam, cryoablation was just another method to kill the cancer. An analogy was if you got shot with a 44 magnum or an AR15 you were going to die. Whichever gun was used, it didn't make any difference. Cryo should be the same and was.

In 2014 the senior surgeon at (now called) Visionary Breast Center in La Quinta, CA began using cryoablation, only this time the killing agent was liquid nitrogen (-300 degrees Fahrenheit or -180 degrees Celsius). The procedure usually lasts 20 minutes. (J) The patient is fully awake, and her significant other was always allowed to enter the procedure room to video tape the procedure and hold the patient's hand. They see the cancer being killed in real time on the ultrasound monitor. Both cryo machines worked well, Sanarus and Ice Cure. The operator can preset the size of the freezeball which is determined by the genetics of the tumor, size, and location.

(K) We introduced the *humanization* in the treatment of breast cancer. This would include the patient and her significant other being allowed to pass their finger through the liquid nitrogen and seeing the nitrogen being transferred from the large dewar into the smaller one used during the procedure. They saw the cloud of nitrogen on the floor. The significant other was allowed to video tape the procedure and hold the patient's hand. While we didn't pick up on the positive effects this had on the patient and her family until later, it was significant in obviating the anxiety, fear, dread, and eliminating the never-ending sense of futility, the usual sequelae of the 'systems' answer to breast cancer [7]. Normal activity is resumed immediately with one patient playing 18 holes of golf because she felt so good. Usually, however, the patients went across the street to Lavender Bistro for a lobster salad and toasted their success with a glass of champagne. That's why we named it The Lavender Procedure.

A total of 25 cases were done on 21 patients. Some had larger tumors (up to 3cm) that refused any traditional therapy. See our ten-year results paper [8].

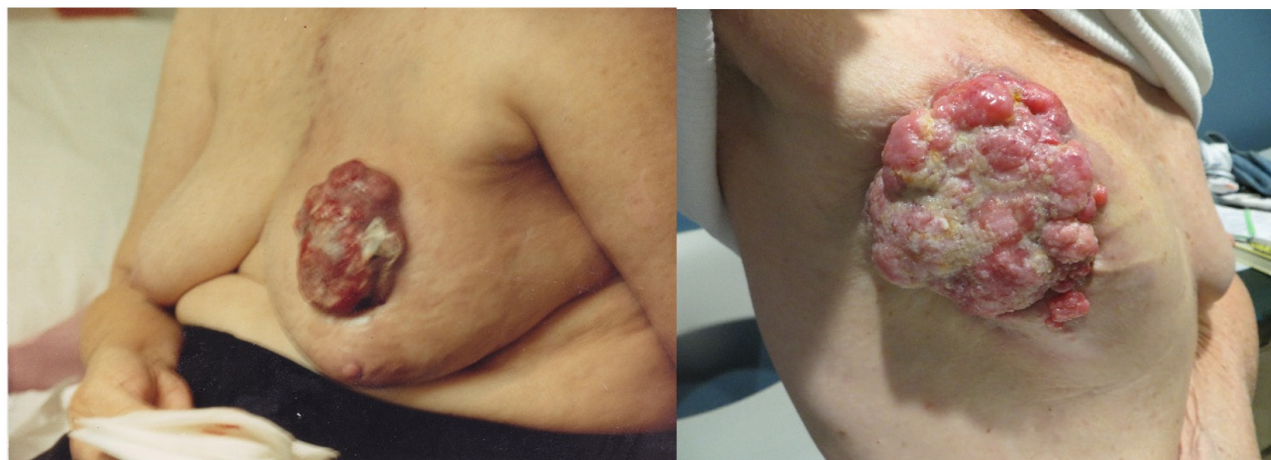
The Lavender Procedure was performed on those larger tumors to prevent the tumor from growing through the skin in those patients who refused any other treatment.

The images below are a couple of patients that refused any traditional treatment and the consequences of such a decision. But importantly, Lavender was the psychological reversal of the foreboding that breast cancer inflicts on people. One patient (see her video on our website thelavenderproject.net) came to the office the day of her procedure dressed in Lavender including painted nails. Upon entering the treatment room, she exclaimed with a smile on her face that, "she was ready for the party." That's the kind of change our patients enjoyed. (K) Further, Lavender is the key to the global ending of the suffering wrought by breast cancer since any trained doctor can do it. A HUGE CANCER CENTER ISN'T NEEDED. The following page shows a couple of patients that were so afraid of what the 'system' would do to them, they let their cancers grow through the skin. How dare the system foist a treatment on women that forces them to opt for disaster. Tumors like these are too far gone for Lavender.

The patient on the left hid that cancer from her husband for three years. The only reason we found out about it was she attended the Bob Hope Classic ball (a prelude to the golf tournament), and she began bleeding through her gown. Women there alerted our surgeon who was also there. The one on the right took seven years to grow through the skin to be the size of your fist. Parts of the tumor often fall off. It bleeds and smells like high heaven. But she was afraid of what the 'system' would do to her with surgery, chemotherapy, and radiation, hard to believe but true. Whose fault is it that patients like these are living in fear in the U.S? We could show more who eventually came to us, but the point is made.

Let's see the contrast of a mastectomy patient vs Lavender.

The image on the left is a bilateral mastectomy (not ours). On her right side the surgeon sutured her up like a football without



regard to the lasting psychological negative impact wrought by some sloppy surgery. The image on the right is taken about 2 minutes after her Lavender Procedure. Her breast remains intact ten years out, no sutures ever and normal activity is resumed immediately. (L) This is all accomplished in an in-office setting for about \$2,500.00 vs 200K for the system's multiple surgeries, which occur 30 to 40 % of the time (usually for retained cancer at the margins), prolonged chemotherapy, as in the case of a Her2 positive tumor, and radiation. Below is a patient seven years out from Lavender undergoing her infrared imaging (no radiation).



Importantly, it's not just cryoablation. We were principal investigators for a genetics company whose test not only predicted the lifetime risk, but also when that risk would likely manifest within ten years of the patient's life. It looked at age related SNPs in the DNA molecule (single nucleotide polymorphisms) that confer risk [8]. Because most breast cancers occur in the post-menopausal state, if a 30 something is determined to be at high risk at age 60, there are 3 decades that are available to have lifestyle changes help possibly prevent the cancer altogether. At ten years out before the cancer should manifest, we can simply accelerate the imaging to two or three times yearly.

This is possible because we used all FDA approved multiple non-radiation diagnostic modalities summarily dismissed by the system like modified military infrared, a pressure sensing devise that can ferret out 5mm cancers, ultrasound, and at times NAF (nipple aspirate fluid). We use mammography as needed but it is not the main focus for detection. Accelerated imaging is something the 'system' can't do because radiation is cumulative. To wit: ask yourself how the 'system' would handle a 30 something who is thought to be at high risk? Of course, the answer is mammography and MRI. The question is how often is the 'system' going to image that patient in order to find a nascent cancer BEFORE it attains the capacity to metastasize?

A case in point is an African American girl named Ananda Lewis, who died of metastatic breast cancer at age 52 on June 11, 2025. It took seven years after her initial diagnosis for the cancer to get her. Why did she have to go through this? Probably because she didn't get mammography. Why? Probably because she was afraid (like many others) of what would happen to her. Lavender, by using non-radiation diagnostic modalities, and having that genetics test,

and having the credo of preserving mind, body, and spirit, may well have prevented her death.



Another case in point is a recent survey by MedStar Health. It found that for women over 40, 59% were not going to adhere to recommended guidelines for mammography, and 23% said they had not had a mammogram (9). Fifty years ago, we all thought that if we had huge cancer centers and mammography on every corner, we would win the battle against breast cancer. We were wrong. We were wrong as evidenced by the increasing number of women dying from breast cancer despite all the 'break throughs', 'game changers' and new drugs. The number now surpasses 43,000 annually in the U.S. that we know of.

It's not just the death toll; it's the devastation caused by the treatment doled out by the 'system'. A little secret no one talks about is how the death certificate is filled out. One of the last things a doctor wants is the coroner breathing down their necks. It's more likely to list a safe cause of death like 'heart failure' than breast cancer. Considering that, the death toll might be higher.

We used the words 'doled out', as defined by Google AI, meaning something that is distributed like food, money or information (in our case breast health care) in small, controlled or limited portions, often implying careful management or stinginess.

That about sums it up instead of a 'whatever it takes' attitude. Everyone knows but no one does anything about it, that health care is not distributed evenly across all people. Lavender would level the playing field overnight as everyone would receive the same care no matter their circumstances. The reader is encouraged to review our published papers which are available on the website thelavenderproject.net, and noted in the references section in this paper. The reader can reach the corresponding author at phil.bretz@gmail.com. The reader can also ask Grok or Google's Gemini to tell you about the Lavender Way/Lavender Procedure.

In closing, it is our position that women's breasts are not to be

trifled with. As a surgeon who does breast surgery, you should care enough to hone your skills so as not to disfigure or mutilate a patient's breast as you cause more harm than you'll ever know. If women are treated like an assembly line tantamount to just changing a tire, they don't like that, so don't do it.

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