Breast Cancer Care in a COVID-19 Pandemic Epicenter

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The COVID-19 pandemic has significantly impacted the way physicians provide medical and surgical care. At the epicenter, in the New York metropolitan area, institutions have severely curtailed performance of nonurgent surgical procedures. The burden of the pandemic has profoundly impacted cancer care and contingency planning for the future delivery of cancer care.

The treatment of malignancies and the prevention of disease progression are usually determined by the acuity of the condition. Surgery remains, for the most part, the primary treatment for breast cancer. Although the surgical therapy of breast cancer has evolved dramatically over past decades, surgery is not optional nor elective when considering treatment for breast cancer. Most breast cancer patients are initially treated with surgery, with elective timing. Moderate delays in timing do not impact surgical outcome, as they are not significantly associated with a change in tumor size nor significant disease progression.1 The oncology literature in fact supports sometimes delaying surgery with neoadjuvant endocrine therapy or chemotherapy. The timing of breast cancer surgery is prioritized according to a variety of factors.

Guidelines and recommendations have been suggested by multispecialty expert panels, such as Society of Surgical Oncology2 and American Society of Breast Surgeons,3 which provide prioritization for timely management of breast cancer during the pandemic. However, the miasma of an infectious disease pandemic demands thoughtful reevaluation of guidelines and, as crisis evolves, fluid restructuring of breast cancer care with buy in from surgeons. Presently, the goals during the COVID-19 pandemic are to protect and conserve staff, supplies, and hospital resources and to minimize risk of widespread exposure. The prioritization of these goals has led to delayed breast cancer surgery for most patients. Fortunately for most patients, the delays in treatment that we have up to now observed will not impact survival.

Surgeons historically have been resistant to major practice changes. The reluctance to advance to new practice algorithms has been well documented in the evolution of breast surgery. Despite trials such as NSABP B-064 demonstrating that breast conservation surgery is as effective as mastectomy, change came very slowly. Whole-breast radiation therapy at first gained little traction. Core needle biopsy for diagnosis of breast cancer still found surgeons slow to adopt as did reduction in lymphadenectomy after sentinel lymph node biopsy in ACOSOGZ0011.5 During this current COVID-19 pandemic, surgeons are now challenged to adopt practices that were always slow to embrace. For instance, active surveillance without surgery as a management strategy for low-risk in situ carcinoma may become new standard of care, at least for the present, with halting of elective surgery for in situ breast carcinoma. A continued pattern of prioritization away from urgent surgery for breast cancer may extend beyond the immediate pandemic. These delays in cancer surgery may become standard of care. Patients have accepted enhanced surveillance and endocrine chemoprevention for in situ and early-stage breast cancers. Whether this pandemic will lead us to elimination of surgery altogether in these cases is unclear.

Surgery-related wait times in fact have not been shown to be directly associated with patient dissatisfaction.6 Patients will now have sufficient time to consider surgical options and various treatments plans, such as partial or total mastectomy and breast reconstruction. Experiences during this delay interval may positively affect decision-making. As patients have extended time to speak with surgeons and carefully consider surgical options, discussions on decision-making between surgeons and patients may lend to quality telemedicine and improved patient satisfaction.

The COVID-19 pandemic has perhaps changed the way in which we approach surgery forever. We are now developing new paradigms based on past prioritization data in the face of a new threat to the health care system. To further understand how this pandemic affects our cancer patients, we look to task forces on the pandemic response and COVID-19 cancer-specific registries.7 We

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are, as all surgeons must, adapting to dire circumstances. William Wycherley wrote: “Necessity, mother of invention.” Thus, in response to social distancing, surgeons are learning how to delicately balance risk and benefit in new, meaningful ways. We are mastering new challenges as surgeon thinkers and scientists.

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