

Breast Cancer: Surgical Treatment Options

Webcast

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Introduction

Andrew Schorr:

Hello and welcome once again to Patient Power in the ihealth section of the Northwestern Memorial Hospital website, nmh.org. I'm Andrew Schorr. Every two weeks we do a program connecting with you a leading Northwestern specialist. Today we're going to talk about breast cancer, and we're going to talk about it in the view of a surgeon. And in a minute I'm going to introduce you to a leading breast cancer surgeon at Northwestern.

You know, 240,000 American women face the reality of breast cancer each year. It's a terrifying diagnosis, yet often if it is discovered early there's so much that can be done. You can go on and live a long life. But then, what do you do? Do you have this sort of surgery? Do you have that sort of surgery? Do you have chemotherapy before surgery? Do you have radiation? Do you have breast reconstruction if you've had an entire breast removed? If you're really worried about a recurrence do you have both breasts removed? And what's your expectation for a recovery? And if you're a younger woman what are the issues around fertility. Lots of questions, and you've been e-mailing in questions. We're going to tackle those as well.

Our guest today is Dr. Jacqueline Jeruss. She's a breast surgeon at the Robert H. Lurie Comprehensive Cancer Center at Northwestern University, and she's an assistant professor in the department of surgery at the Northwestern University Feinberg School of Medicine.

Dr. Jeruss, thanks for being with us today.

Dr. Jeruss:

Oh, thank you. I'm delighted to be able to participate.

Surgical Decision-Making

Andrew Schorr:

Dr. Jeruss, you see it every day. A woman newly diagnosed with cancer. She's terrified. All these terms about--you know, we used to think of where is the cancer and how big is it and now we're starting to learn about types and there's sentinel node biopsies to see, well, gee, has the cancer spread. All sorts of things come into play that a woman has never heard of, and what she really wants to do is be cured

and go on with her life and if possible can save or have breast conserving surgery if that's an option. How do women sort this out? It's a very emotional time. How do you help women work through that?

Dr. Jeruss:

Well, I think that certainly, as you've discussed, there definitely are technical issues that play into surgical decision-making for breast cancer, but then there are also psychological issues as well. And the way that I will typically approach a newly diagnosed patient is first do everything I can to characterize the disease in the most objective sense possible. And that often entails several different imaging modalities. Now we use mammography as well as ultrasound and often MRI in working up a newly diagnosed patient. And after doing this we are able to really establish--and often with multiple biopsies, which I know can be at times very distressing but a very necessary component of establishing a clear understanding of the disease as well as the disease extent. Once we've done all of these things we're really able to sit down with a patient and map out where the disease is in the breast and by doing so establish a treatment plan.

So I guess what I mean by saying this is that once we understand the extent of the disease in a breast we will know if a patient up front meets specific criteria for breast conservation or would be better served by having mastectomy. And we'll also know if the patient is interested in breast conservation but is not a good candidate at the time of presentation that there are certain patients who would also benefit from chemotherapy before surgery to hopefully shrink the tumor size to a point where breast conservation would be feasible.

So what ends up happening is that we obtain an extensive radiologic work-up that often entails biopsies, sometimes through different radiologic modalities, to establish an understanding about disease extent, and then we can set a patient up for what they can expect when they're starting to begin to think about surgery, and that would either be breast conservation, mastectomy or the possibility of breast conservation after neoadjuvant therapy.

Andrew Schorr:

Now, a woman is diagnosed with breast cancer let's say this week and she wants it out. How urgent is it that this, you know, like on a race track this happens really fast? Often a woman will say, I want it out. Take off one breast, maybe take off the other, and let's do it next week. How long is this cancer likely been developing, and how much time do you have to be more thoughtful in your decision?

Dr. Jeruss:

Well, we like to think about breast cancer in the majority of circumstances, certainly not all circumstances, as a cancer in slow motion. So optimally from the time that a patient would present to our office we would like for a patient with invasive breast cancer to have a surgical plan established and a surgery scheduled

within a month. So that really does afford a fair amount of thoughtful consideration and appropriate planning for a patient, and it's not necessarily a, quote-unquote, surgical or oncologic emergency.

Now, there are some circumstances that fall out of this month parameter. In a more favorable light, patients who present with DCIS we often will extend that time period from diagnosis to surgical planning if the patient has extenuating circumstances or just wants to do some soul searching before coming to a decision in terms of surgical planning. To the contrary patients who present with inflammatory disease...

Andrew Schorr:

Right.

Dr. Jeruss:

Certainly those patients fall into a different criteria, and we will act very fast, oftentimes within the week or within a few days of diagnosis to institute therapy. So inflammatory cancer certainly falls out of this cancer in slow motion type of philosophy. But that withstanding there is time to really pursue and educate ourselves about the patient and the patient about her situation and so that a good and thoughtful decision can be made about surgical planning. I think that's important to stress. While this is a crisis and it is something that is critical there often is time to sit back and think about the situation in a very linear way so that a good decision can be made from both an oncologic standpoint and a patient's psychological satisfaction standpoint.

Consulting a Plastic Surgeon

Andrew Schorr:

Great points. Now, Dr. Jeruss, looking at that kind of journey as far as surgery goes, when that comes into play, for a woman who may have a more extensive surgery like a modified radical mastectomy, then the discussion can also be about reconstruction. At the Lurie Cancer Center do you have the ability then to also bring a plastic surgeon into the discussion and say, well, how can this all work together? When is it appropriate? Is it done immediately afterwards or at a later time? How does that typically happen?

Dr. Jeruss:

Speaking from my practice I can say that here at Northwestern we are tremendous advocates for reconstruction, and we really have not put an age capitation on who should or can get reconstructed. In fact, I just last week did a reconstructive surgery on an 83-year-old patient who lives a very active life, and we felt very seriously that this was going to improve her quality of life. So oftentimes we will

look at the patient and her disease process. And again for patients with inflammatory cancer, we are not in the practice of actively reconstructing them at the time of surgery.

That group withstanding, all other patients undergoing mastectomy we very much encourage immediate reconstruction if it's possible. And there are certain patients whose health or well-being just doesn't allow us this, but I would argue that they're a small minority, and almost all other patients who are interested in reconstruction we will have them meet with a plastic surgeon within--often on the same day as they come in for their consultation with us, a surgical oncologist, or certainly within the week to discuss the options available, either a tissue expander or tram flap reconstruction.

And there are some unresolved questions regarding the use of radiation therapy in conjunction with immediate reconstruction. Certainly here at Northwestern we are not in practice of radiating patients who undergo tram like or tissue flap reconstructions, and so patients who are interested in that type of reconstruction who are going to need radiation will often have that done in a delayed fashion, which we've seen wonderful results with.

There are some plastic surgeons who we work with who will radiate patients who have tissue expanders in place, and that is very nice for patients who can then have an immediate reconstruction, have some type of breast form during the time in which they are being radiated, and I think that that does afford a tremendous sense of satisfaction to patients. But I do think it's important to mention that there are certainly a lot of different philosophical disputes about radiating patients with implants in place that you may find different opinions about depending on the institution which you are obtaining an opinion from, but certainly here at Northwestern we will radiate patients who have an implant in place if the situation is appropriate. So I think that in summary we are really advocating for reconstruction for nearly all the patients that we see who are opting for mastectomy.

Getting a Second Opinion

Andrew Schorr:

Dr. Jeruss, so you're a surgeon, a woman comes to see you, puts her trust in you. But often there's that nagging feeling, well, should I get a second opinion. I don't want to offend the doctor. Or someone comes to you for a second opinion. What's your view of second opinions as people try to sort this out?

Dr. Jeruss:

To be quite honest, I'm a huge advocate of obtaining second opinions, or if necessary we have patients who seek multiple opinions. And I feel that that's an important part of the process for certain patients and as I've mentioned earlier I do

think that there is often time to do this. And I feel that way because once the patient goes to surgery they're committed and that's the decision that they will live with for the rest of their lives, and I think that that has to be a very durable decision. Certainly I feel that way from an oncologic standpoint but also from the psychologic standpoint. And if a patient needs to have their thought process and the plan that they've come to validated by someone else at an outside institution I think that that is fine. And as I say I certainly feel that as long as it's not going to derail or delay care beyond the time points which I had mentioned, from a month to six weeks, I think that that's very reasonable because it does oftentimes help a patient to finally come to terms with the decision that they realize is best for them.

So I really just support whatever is going to help the patient get to that end point. So as long as the opinion is within an established institution where we know that certain standards of care are being upheld I think that it's a very good process to undergo.

Fertility Issues in Young Women

Andrew Schorr:

Dr. Jeruss, now, most often, I guess, breast cancer is diagnosed in somebody who is postmenopausal, but it certainly happens in younger women who are still in childbearing years. And you talk about chemotherapy and you talk about radiation and just the whole idea of surgery to the breast. Well, let's talk about fertility issues in younger women. Where does that come into play? And what do you discuss with women these days?

Dr. Jeruss:

I think that this is a very cutting edge topic to bring to light for young patients with cancer and not just breast cancer. We understand that most young patients with breast cancer that is invasive, certainly not our patients with DCIS but our patients with invasive disease are going to receive an opinion that in all likelihood will be including chemotherapy as part of the treatment process. And how that chemotherapy will affect a woman's long-term ability to conceive a child is certainly different for each individual patient as ovarian reserve is really unique to each individual. So here at Northwestern, we are a part of a consortium of institutions around the country that has established an oncofertility program for young patients with cancer where several different modalities for fertility preservation are available.

And there are options that span from just being involved in research towards fertility preservation up towards embryo cryopreservation and including tissue preservation, ovarian tissue preservation as well as oocyte cryopreservation. So if you would come to an institution like Northwestern or one of our sister institutions within the US you could meet with consultants who could walk the patient through the options available to them, help them to get through the appropriate

preoperative testing, to establish what their ovarian reserve was and then guide them through the decisions that would be best for them dependent upon their partner status or their readiness to commit to some type of generational or provision of generational hope.

Just a few weeks ago I had a young women come into my office who is in her early 30s who decided that she wanted to go through embryo cryopreservation, and we put her on a fast track through what is called emergency IVF so that she was able to preserve four embryos and then begin her neoadjuvant chemotherapy knowing that regardless of how that chemotherapy was going to affect her fertility that she and her husband had those embryos in the bank before she started treatment. So I think that those kinds of experiences at cancer centers like Northwestern are really going to open up the door for younger patients now to think about having children, whereas in the past, this would not have been a potential option for them.

So I think that certainly the desire to have a child is a very innately human and powerful experience, and I think as cancer treatments become more and more life preserving, as we make further advances in the lab and they can translate into the clinic, we want to ensure the most full life for these young patients who are surviving as possible. And I think that this oncofertility initiative and preserving the ability for a woman to have a child after cancer is a very big part of this preservation of a full life after cancer.

Andrew Schorr:

Right. And of course we should underscore for people that that is really what's true for most women with breast cancer is they do go on to have a full life.

Dr. Jeruss:

Absolutely. Absolutely. I do agree with you. I can't stress that enough. So now this is just one more big piece of that life, fullness of life that we are taking very seriously and are starting to really establish here at Northwestern.

Side Effects of Surgery

Andrew Schorr:

All right. Let's go on to thoughts about post surgical concerns. So we've gotten a number of questions, and they ask about things like lymphedema, and they ask about healing and when they can really feel like they've recovered from the surgery. So let's tackle some of those. First of all, a word about lymphedema. So this is the swelling that can happen. Often it goes away but not always. How can that be minimized, Doctor, and what--if women go into surgery going in with their eyes open knowing that sometimes this is a side effect of the surgery?

Dr. Jeruss:

First of all, I think it's important to state that the lymphedema rates in modern times, in 2008, are considerably less than they were in years past, and a lot of that is because we are now doing sentinel node biopsies on nearly every patient who comes in with invasive disease. And the incidence of complicating lymphedema in the setting of sentinel lymph node biopsy has considerably decreased the effects of lymphedema. That being said, we also do not do the type of radical vein-injuring surgeries that we did in years past for patients who do require an axillary dissection. So I would have to say that I think that lymphedema while it is still an issue for some patients has become much less of an issue due to the more modern techniques that we use in the operating room now on a daily basis.

For those patients who are at highest risk for lymphedema it would be those patients who have locally advanced disease with multiple lymph nodes positive who then go on to have axillary dissection and then have radiation therapy to axillary fields in addition to surgery. And so for those patients lymphedema remains as very real issue.

And for those patients we do actually have several different options available for management. And so some of them include wearing a lymphedema sleeve, going to lymphedema massage therapy, basically I would say using common sense in terms of taking careful measures to watch skin injury, to attempt to avoid injury. If you're going to be gardening make sure you wear gardening gloves. If you're going to have your nails done ask the manicurist to be appropriately cautious when cutting back cuticles or just forego that cuticle issue entirely. If you're going to take a transcontinental flight or a long flight of any kind that would be a time when you might want to wear your lymphedema sleeve. If you do have a skin injury it would be time to come in to a doctor and I would recommend antibiotic ointment and just careful observation.

And so I think for a majority of us feel for patients who are not at that highest risk category where they're undergoing axillary dissection and then axillary field radiation, for patients who are undergoing axillary dissection alone we ask them to really try to go out and live as normal a life as they can and try not to worry about the potential for lymphedema. Because arguably, if it is going to happen, it is, but if certain things can be avoided like these issues I previously mentioned the majority of our patients are actually going on and not having a tremendous burden from lymphedema any more.

Andrew Schorr:

That's good to know.

Dr. Jeruss:

I think it's important to keep that problem in perspective because I think a lot of women worry a tremendous amount about it, but it isn't as much of a forefront concern as it has been in the past.

Listener Questions

Andrew Schorr:

Of course surrounding the whole area of breast cancer for a woman is always a lot of worry, worry about this, worry about that. Sarah from Salt Lake City, Utah writes in. She's been going through neoadjuvant chemotherapy and then is going to have surgery. And she says, "Will recovery from the surgery be harder because my body is weak from chemo?"

Dr. Jeruss:

Well, I think that we tend to wait about three weeks to a month after a patient has completed their neoadjuvant chemotherapy to move forward with surgery. The majority of my patients just do beautifully afterwards, and I know that they are coming from a different mindset having had neoadjuvant treatment, and I think they have a different perspective about their cancer having gone through what is arguably the most arduous component of their care up front. But just the same, patients who I've taken care of who have surgery after neoadjuvant therapy tend to do as well or nearly as well as the patients who go through surgery first. So I think while psychologically there is certainly a different mindset about the process, physically my patients have done beautifully subsequent to neoadjuvant therapy.

Andrew Schorr:

Here's a question from Danny from Baton Rouge, Louisiana. She said, "I'm two months post bilateral mastectomy, and my incisions are healing, and I'm feeling like my old self. The problem: In the middle of my chest, the uncut area between the two incisions is still tender and swollen. I thought this would go down after my incision started healing and wasn't too concerned since I figured this area was getting extra activity and increased blood flow."

So she's worried about that. She says it makes wearing a bra or seat belt very uncomfortable. Should she be worried is what she's asking.

Dr. Jeruss:

Well, it is a little bit difficult for me without being able to examine her to render a true opinion, but it sounds like what she needs to do is to go back to the surgeon who operated on her and just be sure--I'm not sure. Did this patient have reconstruction as well?

Andrew Schorr:

She doesn't say.

Dr. Jeruss:

So that would be another issue as well. Sometimes the locality of the tissue expander can be a bit uncomfortable for patients until they get their permanent implant. So that might be another issue that is at hand if the patient is getting an expansion from an implant--from an expander prior to an implant there is often a lot of pulling and some discomfort which will be considerably mitigated once the patient gets their implant in place.

If this patient does not have implant reconstruction then it leads me to wonder if the patient has other issues like could the patient have costochondritis and maybe they need to be worked up in a more rigorous way, maybe with a chest x-ray or a CT scan just to be sure that there's nothing that has gone on that has affected the patient's sternum. But it's hard for me to make a qualitative judgment about that.

Andrew Schorr:

Right. We can't practice medicine over the internet.

Dr. Jeruss:

Right. Sounds like go back to your doctor and get yourself a little bit more carefully evaluated.

Andrew Schorr:

Okay. Couple of other questions and that is about reconstruction. So people remember over the years the news about breast implants. So if a woman chose to have a breast implant is there a concern that that could mask the early signs of a recurrence as they're followed over many years?

Dr. Jeruss:

Well, at this point in time we do not have any data that substantiates that implants--which are now placed underneath the muscle, we don't really do any prepectoral implants anymore--there's no evidence to state that that would in any way impede the discovery of recurrence, because as I stated the implants go beneath the muscle. So the area where the patient would recur, the chest wall or the skin flaps, remain eminently accessible for examination both radiographically as well as for physical exam. So I would not think that an implant should be a concern for a patient in terms of being carefully followed for recurrence.

Recurrence

Andrew Schorr:

Now, this word "recurrence" is terrifying. You go through all this once. You don't at all want it to happen again. Some women must come to you and say, You know what, Doctor, I want the opposite breast removed too. Barring that there's a genetic connection in the family where the likelihood is higher, when that's not the

case, which is most of the time, how do you counsel women as they work through that decision, when they just want it out and maybe don't want to have the fear of a recurrence?

Dr. Jeruss:

Well, I think that's an important thing to mention especially because as you may have heard in the press recently there has been some information stating that bilateral mastectomy is on the rise in this country, and that's been a subject of discussion for my practice certainly. I have to say, as you mention, for patients who are gene carriers I do feel it is a reasonable decision to pursue bilateral mastectomy. But taking that group out of the equation and just looking at the patients who come in with a sporadic, genetically unrelated breast cancer, I do not think all these patients need bilateral mastectomies --When you're facing a new diagnosis and you're just in the process of acceptance about the diagnosis a lot of different thoughts will pass through a patient's mind.

I think what's very important is to allow the patient to have an appropriate amount of time to discuss their situation, to hear the options as they're laid out, understand what the impact on survival is for any type of local surgery and then to really say that after this whole process has taken place, which can sometimes take a week or two in terms of question and answer type sessions with the patient and her surgeon, that after that point in time I think the patient will often come to a decision that's really best for her. And I think that if a patient really perceives that bilateral mastectomy is going to give them the piece of mind to move on with the rest of their life and not think about cancer every day, multiple times a day, and be truly derailed by the fear of a recurrence, then I would be willing to certainly entertain that.

But I myself would argue that probably the best way to approach most cancers is to deal with the affected side, and as we have just been discussing this, I think that in the end insurance companies are going to probably stop or they're going to start to question the need for a prophylactic mastectomy in a patient who is not a gene carrier. And I don't know if we're going to be able to continue to pursue these surgeries for patients that do not have an actual objective indication for them because there is really no substantiating data to say that in a patient that isn't a gene carrier a prophylactic mastectomy is ultimately going to impact long-term outcome. And I think that's a very important thing to take into consideration when you're making this decision.

And so for those patients psychologically that just cannot move on with their lives, by all means I think it is important to discuss this. But for the majority of patients who are able to take the time to really establish an understanding of what they're dealing with, I think many of them after a week or two come to a decision where they want to deal with their affected side, and they feel comfortable moving ahead with that.

Promise in Research

Andrew Schorr:

Dr. Jeruss, just in the couple of minutes left, I know you are involved very much in research and helping take a look at what's going on with the breast cancer cells and hopefully that will lead to more personalized care and more yet scientific decisions on what's right for each individual woman affected by breast cancer. Where are we now with your research and what's the promise of it?

Dr. Jeruss:

Well, the work that I do in the lab is focused on a specific tumor suppresser in breast cancer, but it also focuses on looking at multiple different tumor suppressers simultaneously. And I think that pushing for a molecular diagnosis of breast cancer really is going to be important for patients, understanding patient prognosis as well as understanding more about how to target therapies specifically for patients who have more refractory disease. And so I think that we have evidence all around us of the progress that's being made in the lab. Oncotype DX has now reached the clinical setting which is the use of a 21-gene assay for patients who are ER positive to better stratify them in regard to risk for recurrence and to better tailor decisions regarding chemotherapy. So when you see something like that happen in your lifetime--additionally, the implementation of sentinel node biopsy in the last decade and a half has really been an unbelievable advance that has really spared patients tremendous surgical morbidity.

I think that there are additionally trials that were phase I years back that are now being FDA approved, treatments like bevacizumab and lapatinib, are reaching the clinical setting. I think that just the number of examples that I can cite just off the top of my head about things that were laboratory based and seemed like the stuff of dreams just within the last decade now being instituted in a clinical setting really inspire me all the time to move forward with my tumor suppressor research in hopes that it will also reach towards some type of targeted therapy for more refractory breast cancer. So my work is coming along, and I think that it is being inspired by the progress that I see being made all around me.

Andrew Schorr:

Well, we wish you well with your research. I'll also mention to our listeners to be sure and listen, if you didn't hear it live, to the replay of our program with a medical oncologist, a leading breast cancer expert also at the Robert H. Lurie Cancer Center, Dr. William Gradishar, and he discusses some of these advances that Dr. Jeruss was just mentioning.

Dr. Jacqueline Jeruss, assistant professor in the department of surgery at Northwestern University's Feinberg School of Medicine and breast cancer surgeon at the Robert H. Lurie Comprehensive Cancer Center at Northwestern University,

thank you so much for sharing your perspectives on breast surgery and advances in breast cancer. We'll have you back another time, and we're going to talk about early detection. Okay?

Dr. Jeruss:

Great. Thanks. It was really just a delight to be able to participate, and if there are any other questions I can answer I'm happy to avail myself here at Northwestern.

Andrew Schorr:

Thank you. And for our listeners, if you'd like more information about Northwestern Memorial Hospital's physicians or services just go to nmh.org, or to request an appointment online with Dr. Jacqueline Jeruss just visit nmh.org.

We will be back on our next program June 10th discussing dermatology, skin cancer prevention and treatment with Dr. Mary Martini.

I'm Andrew Schorr. You've been listening to Patient Power on ihealth brought to you by Northwestern Memorial Hospital.

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