People get started now.

Thanks for joining us for Smile shares with primary care this month.

We’re focused on breast cancer awareness month and the next slide.

Oh, my name is Anne Chang.

I’m the deputy CMO and Chief integration officer for SMILo.

I’m a long medical oncologist.

and I developed this this,

this series with Karen Brown and EMG

and Smiler working together to really.
Focus on the primary care perspective on cancer and hematology and the audience for primary care clinicians and we have our primary care panelist and smilo physicians. This is a monthly series. So if you like us then come back. It’s always the first Tuesday. We started last month and really this is an opportunity to. To focus on questions that primary care may have about cancer topics and we really felt that it wasn’t something that where we wanted the
00:01:12.140 --> 00:01:13.886 specialist to tell primary care what they wanted to know but really ask primary care what the topics are that you have questions about.

00:01:20.430 --> 00:01:22.985 So we're going to go into introductions and then we'll go into a case presentation with our experts and really we'll let you have about 10 minutes available for questions answers that you.

00:01:27.486 --> 00:01:29.788 We put in the chat as we're going along or or ask at that time.

00:01:30.150 --> 00:01:31.643 So I'm going to introduce Karen Brown first. Karen, if you can say a few words and...
then and then. Start with the interests of our faculty. Sure. No, I just want to thank you and of course, all of our friends for sharing with us. You know, we are always stronger together and new cancer is. Can be a really tough time for our patients and for us to support our patients. So I think the more that we can do to coordinate both officially and unofficially and formally and informally between us that the better care that our patients will receive. And I would also like to point out that this evening's panel is
NOTE Confidence: 0.791756917692308
00:02:23.756 --> 00:02:26.248 largely on the the New Haven region.
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00:02:26.250 --> 00:02:28.704 So we're hoping to kind of
NOTE Confidence: 0.791756917692308
00:02:28.704 --> 00:02:30.866 highlight on different regions and
NOTE Confidence: 0.791756917692308
00:02:30.866 --> 00:02:32.646 I’ll introduce Joe Bennett,
NOTE Confidence: 0.791756917692308
00:02:32.650 --> 00:02:34.876 Toski who is one of our star.
NOTE Confidence: 0.791756917692308
00:02:34.880 --> 00:02:37.125 EMG primary care clinicians Jill
NOTE Confidence: 0.791756917692308
00:02:37.125 --> 00:02:39.370 attended medical school at the
NOTE Confidence: 0.791756917692308
00:02:39.449 --> 00:02:42.054 University of Connecticut and completed
NOTE Confidence: 0.791756917692308
00:02:42.054 --> 00:02:44.659 residency in primary care general
NOTE Confidence: 0.791756917692308
00:02:44.733 --> 00:02:47.158 internal medicine at Mass General.
NOTE Confidence: 0.791756917692308
00:02:47.160 --> 00:02:49.435 She returned to Connecticut to
NOTE Confidence: 0.791756917692308
00:02:49.435 --> 00:02:51.255 practice general internal medicine,
NOTE Confidence: 0.791756917692308
00:02:51.260 --> 00:02:52.620 where I met her.
NOTE Confidence: 0.791756917692308
00:02:52.620 --> 00:02:54.320 She was an assistant clinical
NOTE Confidence: 0.791756917692308
00:02:54.320 --> 00:02:56.005 professor and working closely to
NOTE Confidence: 0.791756917692308
00:02:56.005 --> 00:02:57.931 educate a lot of the residents
NOTE Confidence: 0.791756917692308
00:02:57.940 --> 00:03:01.475 who were training with us at Yale.
NOTE Confidence: 0.791756917692308
00:03:01.480 --> 00:03:03.010 The ambulatory setting.
NOTE Confidence: 0.791756917692308
00:03:03.010 --> 00:03:06.580 She and her practice joined a NE
NOTE Confidence: 0.791756917692308
00:03:06.672 --> 00:03:10.678 Medical Group in 2018 and are clearly
NOTE Confidence: 0.791756917692308
00:03:10.678 --> 00:03:13.226 provide excellent patient care.
NOTE Confidence: 0.791756917692308
00:03:13.230 --> 00:03:16.790 We get constant demands to see how many
NOTE Confidence: 0.791756917692308
00:03:16.790 --> 00:03:19.321 more patients they can follow because
NOTE Confidence: 0.791756917692308
00:03:19.321 --> 00:03:21.649 people love them and they do such a
NOTE Confidence: 0.791756917692308
00:03:21.649 --> 00:03:23.708 good job taking care of patients.
NOTE Confidence: 0.791756917692308
00:03:23.710 --> 00:03:25.740 She's additionally now the medical
NOTE Confidence: 0.791756917692308
00:03:25.740 --> 00:03:28.210 director for University of New Haven,
NOTE Confidence: 0.791756917692308
00:03:28.210 --> 00:03:32.458 so engaging in some student health as well.
NOTE Confidence: 0.791756917692308
00:03:32.460 --> 00:03:34.315 I'll pass it back to you to
NOTE Confidence: 0.791756917692308
00:03:34.315 --> 00:03:35.110 introduce our specialist.
NOTE Confidence: 0.696368982857143
00:03:35.220 --> 00:03:39.994 So Rachel Greenup is an associate professor.
00:03:40.000 --> 00:03:42.190 Surgery. She’s a breast surgeon.
00:03:42.190 --> 00:03:43.948 She’s our chief of breast surgery.
00:03:43.950 --> 00:03:48.297 And she came from, came from Wisconsin,
00:03:48.300 --> 00:03:50.470 where she did her residency and then
00:03:50.470 --> 00:03:53.387 went on to do her fellowship at the MGH,
00:03:53.390 --> 00:03:56.684 Dana Farber and Brigham and actually
00:03:56.684 --> 00:04:02.646 came before joining Yale from Duke,
00:04:02.646 --> 00:04:04.850 where she founded that Duke Breast
00:04:04.850 --> 00:04:09.155 Cancer Outcomes Research Group and.
00:04:09.160 --> 00:04:13.260 And she has been here how long?
00:04:13.260 --> 00:04:15.380 Yes, and it has a real focus on
00:04:15.380 --> 00:04:17.539 care of women with young women
00:04:17.539 --> 00:04:19.867 with breast cancer and early onset
00:04:19.942 --> 00:04:22.257 breast cancer and health equities.
Sarah Shellhorn is a colleague of mine, associate professor of medicine, chief ambulatory officer for Smilo, and she came from. She did her residency at Beth Israel Deaconess in Boston and came did her fellowship at MD Anderson. And she is really interested around patient care, using technology to help patients optimize adherence to oral therapies and, you know, studying patient reported outcomes. And she’s the physician leader of our faculty academic practice and also very interested in early onset breast cancer.
00:05:03.690 --> 00:05:04.580 Why do you stay here?

00:05:04.580 --> 00:05:05.996 And another colleague, associate Professor, Professor of medicine, he is the medical director for our Smilow Cancer Care Center in Guildford.

00:05:10.720 --> 00:05:15.544 Y ellow affiliated hospital for residency. He was chief resident and then did his fellowship at Cornell University, met while Medical College, and is a Fellow of the American College of Physicians and also very interested in long term care of patients with breast cancer.
So without further ado,

but with our Distinguished faculty panel,

I'll hand it over to Jill.

Good evening, everyone and thank you.

Thank you for the introduction.

Dan and Karen, we and NMG who are seeing patients see and have conversations with over 100,000 women regarding breast cancer screening annually and we order hundreds of mammograms. So this topic is very important to us.

We utilize the health maintenance tab in EPIC as an opportunity to remind ourselves and our patients of when their mammograms are due and to make sure they’re done in a timely fashion.
And one of the focuses we wanted to make sure was recognizing those who are at increased risk of breast cancer and might need earlier or more advanced level screening. So with that, I'll start our case with a 35 year old nulliparous female with a history of obesity, PCOS and Raynauds who presents for advice regarding breast cancer screening and prevention as her mother, maternal aunt and premenopausal older sister all have a history of breast cancer. So questions regarding this case are...
what screening imaging is recommended in light of her family history and at what intervals is genetic testing indicated? What tests and how is it best to arrange that? And what, if any, preventative strategies are recommended regarding prophylaxis or surgery?

And so Doctor Greenup is going to take this on. Thank you, Rachel. Thank you for having me. So breast cancer screening has been a topic of great controversy for many years. And it flares up in the lay
press every three to five years.

Every different society has specific guidelines, but the next slide will show you that the US Preventive Task Force guideline demonstrates that women under 50 screening should be made on an individual basis and take patient context into account. So certainly a strong family history. We recommend women begin screening with annual mammogram and or ultrasound based on the youngest. Age of the individual and their family at diagnosis.
So for example, in this 35 year old woman who had a history of a mother, maternal aunt, and premenopausal older sister, we would think about the ages of their diagnosis and recommend screening for her about 10 years younger than that earliest diagnosis. The US Preventive Task Force guidelines were most controversial because they did recommend that screening could be considered in every other year in women 50 to 74, and they actually said that there was potentially no benefit.
to clinical breast exam patients.

Asked us about this a lot.

I still encourage women who are comfortable doing a monthly breast exam to do so.

Regardless of what the data shows, we still meet many women who find their own breast cancer.

The next slide shows the American Cancer Society guidelines, and again, this is what most of us in academic programs adhere to, which includes.

Annual screening for women 40 to 44, again lifetime risk should be
considered and then switching to mammograms every two years as women are 55 and older, again depending on risk. The next slide shows the American Society of Breast surgeons position statement on screening mammogram and this came out in 2019 in response to differing opinions around frequency and type of imaging for average risk women and these guidelines. Really thoughtful in considering not only family history but also breast density and the value of supplemental imaging. And I recommend if anyone’s
interested you can go on the SBS website and look at these in detail. But the next slide will outline. When women, certainly who have breast cancer, was, we see a finding on mammogram followed by ultrasound plus minus biopsy. Next slide. If there's any concern about density or family history being exacerbated, inclusion of MRI, 3D mammography screening, ultrasound or supplemental imaging such as contrast enhanced mammography, which is a less common currently across the country,
but we’re hoping to launch that in our smile network in the near future. There’s opportunities to do so without pushback from insurance coverage. In terms of screening or testing for a hereditary Cancer syndrome, we typically depended on the NCCN guidelines and these as many of you know, we’re really based on both a personal history of breast cancer and a family history of breast cancer. It looked at potential for genetic testing for BRCA one and two mutation carriers, any woman 45 or younger women younger
than 50 with first, second or third relative women with family history of both breast and GYN cancers, including ovarian or fallopian tube or primary peritoneal, it did account for. Bilateral breast cancer, triple negative phenotype under age 60 and individuals with strong family history of Melanoma and pancreas cancer. Next slide. Again, the American Society of Breast Surgeons did update our genetic testing for hereditary breast cancer guidelines to say that any
woman with a known breast cancer

should have access to a genetic counseling and potential testing,

knowing that a broad genetic testing panels can include variants of unknown significance that can cause difficulty in discussions and are often not clinically actionable.

And I think that brings us to our screening key points.

And the final is that average risk women who need screening can.

Be considered for every other year starting at age 50,

but all current guidelines recommend we account for patient family history and
00:11:48.350 --> 00:11:50.306 personal history including biopsies.

00:11:50.310 --> 00:11:52.374 We should consider screening every year in women 40 or over.

00:11:52.374 --> 00:11:56.050 It’s important to screen women 25 and over for higher risk of breast cancer.

00:11:58.297 --> 00:12:00.680 That will help our radiology colleagues think about supplemental ultrasound and or MRI related to breast density.

00:12:00.680 --> 00:12:02.714 And again, we do have a robust program at the breast center that includes breast surgery EP’s who can help absorb these patients if they need a medical home for their Breast Cancer Care.

00:12:02.720 --> 00:12:05.702 Thank you. So now we’re
taking this same patient and moving

Now she’s presenting at age 49

And so when we come to this case

the questions that come up are

what are the appropriate imaging

orders and what is the appropriate

method for referring for biopsy.

Should the patient go straight to

surgery should be a radiological biopsy

and if the biopsy is positive?

What’s the order of referral and

when should she see oncology in

relationship to her definitive surgery?

I believe Rachel is taking this one as well.
Yeah. So it’s certainly a 49 year old woman with a palpable breast mass initially should undergo diagnostic mammogram, a diagnostic ultrasound and certainly consideration of MRI based on breast density is very reasonable.

I typically have this discussion with our radiologist. Sometimes the reports will say things such as extremely dense breast MRI is recommended. Other times it’s valuable to think about the pros and cons of the MRI in partnership with the patient. Ourselves at Yale are we do refer.
these women for biopsy and or second opinion if the imaging is done outside so that women can get both a face to face consultation with a provider in our breast center and also have a formal review of their screening imaging that led to the. The work up or the area of concern screening imaging being their annual imaging that caught the abnormality and diagnostic being the additional workup that led to diagnosis. When we think about breast surgery and typically our breast surgeons are the first frontline providers that see these patients,
there are many options. So women who are eligible with small breast cancers can undergo lumpectomy or mastectomy if they are found to not have a hereditary cancer syndrome. And we know their risk of local recurrence remains very low. Typically recommend that women less than 70 years old with a triple negative or her two positive breast cancers have lumpectomy.
followed by radiation.

There are some exceptions and older women with favorable hormone receptor positive breast cancers where radiation can be safely omitted.

The recovery time is shorter.

I always tell patients they get back to their lives a little sooner and the complication rate is low when we think about mastectomy.

It’s a bigger surgery when we add reconstruction.

That’s a second really important layer from a psychosocial perspective, but does not contribute to improve cancer outcomes.
Many women with small tumors after mastectomy won’t need radiation. They can be exposed to several surgeries and or revisions and there’s a higher rates of complications especially if patients are smokers have diabetes or other comorbidities. Next slide and these are just some pictures that everyone on the call is aware of. Lumpectomy means we’re removing the tumor with negative margins typically following by radiation. Next slide we used to be very reliant on radiology putting a wire in next slide and now we have the improved.
Sophisticated technology like radioactive seeds or tag localizers that women can have placed up to five days prior to their lumpectomy without needing to have the wire. Out of their breasted day of surgery, we also have good data. It’s more comfortable, patients have better satisfaction and their margin rates are improved with smaller resection specimens. Next slide when we think about mastectomy obviously that’s removing all of the breast tissue that can happen with or without reconstruction. We have a great group of reconstructive
surgeons across the region that do both implant based and micro vascular reconstruction and we’re doing an increasing number of. Media implant reconstruction, which does consolidate the recovery time for our patients.

Next, I think one of the things that comes up a lot when I meet women, especially our younger patients like this one. As the discussion about whether there’s benefit of removing their healthy opposite breast through prophylactic mastectomy on the contralateral side.
and the rates of this has actually tripled in the last few decades, probably related to cultural and kind of pop culture conversations. We know that after one breast cancer, a woman’s risk of a contralateral cancer is low. It’s between .1 and .5% per year, and that removing a healthy breast outside of a hereditary cancer syndrome does not improve survival. And there is also an associated higher risk when we do more surgery inherent to things like bleeding infection. But ultimately our patients do report that sometimes cosmetic
outcomes and a Peace of Mind are reasons that prompt them to.
Pursue a double mastectomy.
When women need radiation, this is external beam radiation. It’s painless. They usually get five days a week for one to 10 weeks. It’s cumulative, so side effects tend to come later or towards the end. This is things like sunburning, fatigue, low risk of secondary cancers. And there can be swelling,
redness, cough.

Some of this related to the site that receives the radiation.

But our radiation colleagues have improved techniques to avoid Android to heart and lungs, and they continue to work towards shorter,

abbreviated courses.

Rachel, if we could just go back to the beginning of the case but just about how you would advise this woman with regard to options prior to her developing her cancer.
in terms of surgical prophylactic surgery or medical therapeutics,
prophylactic medicine medications.
What is the, how do you, What is the, how do you phrase that conversation?
With her given her risk and whether or not if she hasn’t known mutation or does not have a mutation but a profound family history.
Yeah, so it’s a complicated discussion. I think ideally women will come in early in the process before they’re kind of ready to sign up for surgery. I first start by taking a good family history and getting a sense of the
00:19:23.050 --> 00:19:25.950 level of family member involvement,
NOTE Confidence: 0.921060155
00:19:25.950 --> 00:19:29.268 at what age family members are diagnosed
NOTE Confidence: 0.921060155
00:19:29.268 --> 00:19:32.860 and how those family members have survived
NOTE Confidence: 0.921060155
00:19:32.860 --> 00:19:35.730 or or not survived their breast cancer.
NOTE Confidence: 0.921060155
00:19:35.730 --> 00:19:37.767 We do see families where there’s many,
NOTE Confidence: 0.921060155
00:19:37.770 --> 00:19:39.270 many women. With breast cancer,
NOTE Confidence: 0.921060155
00:19:39.270 --> 00:19:41.934 but they’re all diagnosed in the
NOTE Confidence: 0.921060155
00:19:41.934 --> 00:19:43.710 postmenopausal setting with screen
NOTE Confidence: 0.921060155
00:19:43.783 --> 00:19:45.618 detected very favorable cancers.
NOTE Confidence: 0.921060155
00:19:45.618 --> 00:19:48.082 And then we see women who have a
NOTE Confidence: 0.921060155
00:19:48.082 --> 00:19:50.319 myriad of young women and their
NOTE Confidence: 0.921060155
00:19:50.319 --> 00:19:52.179 family diagnosed with very highly
NOTE Confidence: 0.921060155
00:19:52.251 --> 00:19:54.496 aggressive breast cancers where the
NOTE Confidence: 0.921060155
00:19:54.496 --> 00:19:56.741 it’s probably more time sensitive.
NOTE Confidence: 0.921060155
00:19:56.750 --> 00:19:58.822 As certainly a woman with this strong
NOTE Confidence: 0.921060155
00:19:58.822 --> 00:20:00.250 family history having a mother,
maternal aunt and older sister,
I would refer her for genetic testing.
Ideally, we refer an effective family member first.
Because if that person's negative,
less likely that the individual in front of us would be a mutation carrier.
Again, screening should start about 10 years younger than the earliest family member was diagnosed.
And my practice for these high risk patients although it is candidly controversial as to to both a 3D mammogram screening ultrasound
00:20:33.060 --> 00:20:35.608 alternating with annual MRI.
NOTE Confidence: 0.921060155
00:20:35.610 --> 00:20:37.485 So we’re staggering imaging that’s
NOTE Confidence: 0.921060155
00:20:37.485 --> 00:20:39.860 being looked at every six months.
NOTE Confidence: 0.921060155
00:20:39.860 --> 00:20:42.036 We do see that some women get fatigued.
NOTE Confidence: 0.921060155
00:20:42.040 --> 00:20:43.360 So it’s a shared decision.
NOTE Confidence: 0.921060155
00:20:43.360 --> 00:20:45.364 We work with them together about
NOTE Confidence: 0.921060155
00:20:45.364 --> 00:20:46.700 what what feels good.
NOTE Confidence: 0.921060155
00:20:46.700 --> 00:20:48.830 I have patients that feel very
NOTE Confidence: 0.921060155
00:20:48.830 --> 00:20:50.250 reassured when they’re imaging
NOTE Confidence: 0.921060155
00:20:50.317 --> 00:20:52.802 is normal and I patients that are
NOTE Confidence: 0.921060155
00:20:52.802 --> 00:20:54.517 probably overestimate their risk of
NOTE Confidence: 0.921060155
00:20:54.517 --> 00:20:56.554 breast cancer the more imaging we do.
NOTE Confidence: 0.921060155
00:20:56.560 --> 00:20:58.522 So it’s important to be thoughtful
NOTE Confidence: 0.921060155
00:20:58.522 --> 00:21:00.909 about how it affects their experience.
NOTE Confidence: 0.82225211
00:21:03.240 --> 00:21:05.520 If she was postmenopausal I,
NOTE Confidence: 0.82225211
00:21:05.520 --> 00:21:07.730 typically the breast tissue becomes
fatty or replace we all know
that 3D mammography and becomes a becomes easier to interpret and.
I think especially if postmenopausal women are nearing end of life or they have multiple comorbidities, discussions around reducing the frequency of imaging is valuable. And we do talk to women about chemo prevention if their family history is very high, certainly if women have both a known BRC 1 mutation and strong family history or bracket 2 mutation. Similarly,
we have good discussions about risk reducing surgery both from a mastectomy perspective and also from a GYN perspective.

Thank you. I think Sarah had her hand raised and she wanted to comment as well.

Jill, I just wanted to add to that, sometimes in women who are at particularly high risk but don’t wish to go the surgical route, chemo prevention is a possibility and chemo prevention sounds much scarier, scarier than it actually is. But Chemoprevention just basically means tamoxifen or sometimes aromatase.
inhibitors which reduce the risk of developing a breast cancer somewhere, a relative risk. 30 to 50%. Over whatever time period they're taking it in, even past that time frame, the issue there. The issue there, excuse me, what is that relative risk reduction may not translate into a large absolute risk reduction and that can get a little bit complicated, but it's certainly something that we we do on occasion for people who are interested. Thank you.
00:22:53.940 --> 00:22:56.728 has surgery and is found to have a
NOTE Confidence: 0.847589669411765
00:22:56.728 --> 00:22:58.373 stage 2A invasive ductal carcinoma.
NOTE Confidence: 0.847589669411765
00:22:58.380 --> 00:23:01.780 The tumor is 2.5 centimeters in grade 3,
NOTE Confidence: 0.847589669411765
00:23:01.780 --> 00:23:03.556 does not involve any lymph nodes,
NOTE Confidence: 0.847589669411765
00:23:03.560 --> 00:23:07.313 and is ER PR positive and her two negative.
NOTE Confidence: 0.847589669411765
00:23:07.320 --> 00:23:09.528 And so we are going to now engage
NOTE Confidence: 0.847589669411765
00:23:09.528 --> 00:23:11.080 in discussion about treatment.
NOTE Confidence: 0.847589669411765
00:23:11.080 --> 00:23:12.800 If she’s pre menopausal,
NOTE Confidence: 0.847589669411765
00:23:12.800 --> 00:23:15.380 what is her appropriate adjuvant treatment
NOTE Confidence: 0.847589669411765
00:23:15.452 --> 00:23:17.507 and what factors are considered?
NOTE Confidence: 0.847589669411765
00:23:17.510 --> 00:23:19.946 How is this different if she’s
NOTE Confidence: 0.847589669411765
00:23:19.946 --> 00:23:22.469 postmenopausal and how long should she
NOTE Confidence: 0.847589669411765
00:23:22.469 --> 00:23:24.941 be on adjuvant hormonal therapy and
NOTE Confidence: 0.847589669411765
00:23:24.941 --> 00:23:27.748 doctor shellhorn’s going to take it away?
NOTE Confidence: 0.847589669411765
00:23:27.750 --> 00:23:28.152 Right.
NOTE Confidence: 0.847589669411765
00:23:28.152 --> 00:23:30.966 So breast cancer treatment in 10 minutes,
no problem.
The the, the initial approach and Rachel did a really lovely job going through the, the definitive local management of breast cancer. When we think about breast cancer, they're really three different modalities, each of which has a different concern. And so very broadly speaking, they're really three different modalities, each of which has a different concern. And so very broadly speaking, surgery, the next slide a little bit, but very broadly speaking, surgery, the purpose of surgery is,
is to take out the cancer and the affected.

Lymph nodes, the areas that we know contain cancer.
The purpose of radiation is to mop up behind the surgeon to get rid of any micro, micro microscopic disease that might reside in the breast or the XL or other lymph nodes.
And then the purpose of medical oncology or systemic therapy is really to reduce the risk of developing metastatic disease in the long run.
So we all have very different concerns.
The sequencing of treatments can be different depending on the clinical circumstance.
Sometimes surgery is done first, and this is particularly helpful to figure out what it is exactly that we’re dealing with. What’s the size of the cancer, how many lymph nodes are involved. You really get a full pathologic picture of the cancer, and if that is going to be used to determine systemic therapy or the need for radiation later on down the road, that can be helpful. Sometimes we use a neoadjuvant approach, meaning before surgery, to give some sort of systemic therapy.
such as chemotherapy, and this is used in generally and more aggressive cancers or very locally advanced cancers when we know that chemotherapy is going to be needed and we don’t need that additional pathology to determine what chemotherapy regimen to use. So just wanted to give a quick word on adjuvant versus neoadjuvant and then we’ll dive into all of that pathologic gobbledygook that Jill told us about in terms of this patients biopsy results. Before we do that, however, I’ve already mentioned over on the right what the roles of surgery, radiation and medical therapy are.
Patients often want to know what their stage is. In fact, almost 100% of the time and stage can be thought of in one of two ways. There’s the anatomic stage, which relies on the size of the tumor and the presence or absence of lymph nodes and their number to determine. How locally advanced a cancer is. More recently we started incorporating some of those things that were mentioned in the biopsy report that Jill read earlier including the grade, which in this case was Grade 3, the estrogen receptor and the progesterone.
receptor status and the her two status.

And we can incorporate those features of the cancer into the tumor size in the lymph node status to come up with what the final stage is and stage correlates. Roughly with prognosis.

So it gets us now the patient's going to have surgery, if the assuming the patient has a lumpectomy, she'll need radiation. How do we decide what kind of medical therapy we're going to recommend for this patient? So next slide?

We first look at the grade. Grade is a measure, broadly speaking,
00:26:48.960 --> 00:26:50.475 of how aggressive the cancer cell looks under the microscope.

00:26:50.475 --> 00:26:51.990 It's incorporating a couple of different things,

00:26:51.990 --> 00:26:53.230 including the architecture,

00:26:53.230 --> 00:26:54.160 nuclear grade and speed of replication.

00:26:54.160 --> 00:26:56.008 And it gives us a sense the higher the grade,

00:26:56.008 --> 00:27:02.117 the more aggressive we may need to be.

00:27:02.120 --> 00:27:03.856 IE the higher grade,

00:27:02.120 --> 00:27:05.144 the more likely the chemo is that chemo is going to be recommended.

00:27:05.144 --> 00:27:07.500 Next slide.

00:27:07.500 --> 00:27:09.636 We get into the estrogen and progesterone receptor.

00:27:09.640 --> 00:27:12.640 So the vast majority,
75 ish percent of all breast cancers are fueled at least in part by the female hormones estrogen and progesterone. And so the presence of estrogen or progesterone near the cancer can lead to more uncontrolled growth. So estrogen and progesterone positive cancers, estrogen and progesterone receptor positive cancers are fueled by hormones, which leads us to talk about some sort of anti hormonal therapy and interfering with that interaction between the ligand and the receptor can lead to decreased gene expression and therefore decreased
cell proliferation in the long run.

So that’s the reason behind these hormone type therapies or rather anti hormone type therapies that we recommend for patients who have this type of breast cancer.

You’ve heard of these drugs. You probably have hundreds of patients on these drugs.

Tamoxifen works as a competitive antagonist of estrogen, and progesterone 6 sits in the pocket of the receptor and prevents breast cancers from growing, or breast cells in general from
being able to grow.

Aromatase inhibitors, on the other hand.

Prevent the peripheral aromatization of steroids into testosterone and into rather testosterone into estrogen.

And prevent the body from being able to make estrogen, and so you remove the leg in entirely so there's nothing to bind to the receptor itself.

The final thing that we look at is the her two status. Her two is a member of the EGFR family of surface receptors, and it can be either normal, also called negative,
or it can be positive and it can be positive in one of two ways. It can be overexpressed on the surface of the cell, or it can be amplified in the nucleus with lots of additional copies of the her two encoding DNA, her two positive cancers in general. Are more aggressive. They in general require chemotherapy and oftentimes we use chemotherapy first. In this setting, you may have heard of the name triple negative breast cancer. Triple negative just means estrogen receptor is negative,
progesterone receptor is negative.

Her two is -, 1, two, triple negative.

Next slide please.

Jill in our preparation for this meeting, Jill shared a risk, shared a story of a patient who came in wanting to discuss her number in this case often refers to something called the Oncotype DX, which is a recurrence score. It’s a number on a scale of zero to 100 and it is a number that is calculated by looking at the gene expression of.

cancer specific genes.
It goes into a patented algorithm by this company genomic health and the number the recurrence scores is spit out. So if that number could be on a scale of zero to 100, it's a complicated, nuanced conversation with patients. But in general, if that number is 25 or lower, patients may not benefit from chemotherapy, and so chemotherapy is likely not to be recommended if that number is higher than 20. And so chemotherapy is likely not to be recommended if that number is higher than 20. So this is a test that we
send to determine whether or not a patient needs chemotherapy. It does correlate a little bit to prognosis, but the real purpose of this test is to determine whether or not we need to use chemotherapy to reduce the risk of micrometastatic disease and subsequent distant relapse and at some point in the future. Umm, I don’t expect you to actually be able to read the slide, but there are a lot of different regimens and your friendly neighborhood oncologist would be more
than happy to discuss any of these chemotherapy regimens with you. I put this up just to show that there are a lot of different regimens with a lot of different side effects, a lot of different schedules and that’s our job to really talk through risks and benefits, potential side effects. Potential toxicities, mainstays of treatment for breast cancer, include taxanes, so Taxol, taxotere, ABRAXANE. Those are some commonly used drugs, sometimes adriamycin or doxorubicin and anthracycline.
Cyclophosphamide, cytoxan and carboplatin. And then, if the cancer is her too positive trust, who's amab? Also known as Herceptin, as well as other anti her two targeting agents. Next slide. So this particular patient would have had most likely, given that it was a high grade cancer, it was larger. She’s premenopausal likely to have a high risk Oncotype. So an Oncotype that’s higher than 26, she likely would have been recommended chemotherapy. However, she also needs to
00:32:43.495 --> 00:32:45.579 go on endocrine therapy.

NOTE Confidence: 0.89534825

00:32:45.580 --> 00:32:48.540 Tamoxifen or an aromatase inhibitor would be indicated.

NOTE Confidence: 0.89534825

00:32:50.204 --> 00:32:53.497 So just to think about who we can use these in.

NOTE Confidence: 0.89534825

00:32:53.500 --> 00:32:56.092 Tamoxifen can be used in in anyone provided they don’t have a risk of or a history of venous thromboembolism or endometrial cancer.

NOTE Confidence: 0.89534825

00:33:01.724 --> 00:33:03.998 Aromatase inhibitors can only be used in post menopausal women and that is largely related to its mechanism.

NOTE Confidence: 0.89534825

00:33:14.825 --> 00:33:15.739 peripheral aromatization.

NOTE Confidence: 0.89534825

00:33:15.740 --> 00:33:18.638 In peripheral tissues, not the ovaries.
But what that leads to is deprivation of estrogen in the body, leading to negative feedback and the ovaries ramping up if used in the absence of ovarian suppression. So aromatase inhibitors can only be used in post menopausal women or women who do not have ovarian function, either surgically, chemically or otherwise. The side effects of the two drugs are a little bit different. Tamoxifen could cause vasomotor symptoms, such as hot flashes. It can cause mood changes. There is a small risk of venous
thromboembolism very small
risk of uterine cancer.
It can be beneficial in patients
with osteoporosis and can lead
to an increase in bone density.
Aromatase inhibitors, on the other hand,
lead to this low estrogen state.
So it’s kind of menopause, Part 2.
It can cause vasomotor symptoms such as
hot flashes, night sweats, vaginal dryness.
Accelerated bone loss.
And so we monitor bone density
very closely in these patients,
usually every other year.
It can lead to increased cholesterol as well.
In terms of monitor monitoring, there’s really no monitoring for tamoxifen other than.

To determining whether or not we should extend endocrine therapy past five years. The slides have disappeared. I’d be happy to take some questions until the slides return. Or we could just go straight into the next phase of the case.

Thank you very much, Sarah. Thank you very much, Sarah.

And we’re going to move into survivorship and new symptoms. So our patient is now 54 years old. She’s tolerating her
adjuvant hormonal therapy.

And we’d like to have a discussion about what risk should we as primary care physicians be aware of those being endocrine, cardiac, pulmonary, psychological and what testing should the primary care physician be prepared to order for those patients.

And in addition, after that conversation, eight years later, our patient presents with new onset of back pain of four weeks duration, which she originally attributed to a strenuous session of gardening.
But rather than improving as would be expected, the pain is worsening. So this would lead us into discussion. Considering her breast cancer history, what are the appropriate next steps in diagnosis and management of her new onset of symptoms given her history? And Doctor Zahir is kindly going to take this on. Thank you. You know, this is, you know, any kind of workup for a patient with history of breast cancer should be based on what was their underlying
00:36:33.760 --> 00:36:35.680 risk and what are the symptoms.
00:36:35.680 --> 00:36:38.052 and obviously this lady is having.
00:36:38.052 --> 00:36:40.236 Persistent back pain issues.
00:36:40.240 --> 00:36:42.320 So we need to have it worked up to make
00:36:42.373 --> 00:36:44.239 sure that there’s nothing you know,
00:36:44.240 --> 00:36:46.459 we that we work it up for,
00:36:46.460 --> 00:36:48.430 whether it’s related to breast
00:36:48.430 --> 00:36:50.936 cancer or related to a treatment
00:36:50.936 --> 00:36:53.247 or related to another etiology.
00:36:53.247 --> 00:36:56.516 So if she’s having persistent back pain,
00:36:56.520 --> 00:36:59.622 she will have a workup that
00:36:59.622 --> 00:37:02.300 could include X-rays or well,
00:37:02.300 --> 00:37:04.514 if there is persistent pain in
00:37:04.514 --> 00:37:06.320 a particular location and MRI,
00:37:06.320 --> 00:37:08.516 or if there are diffuse symptoms.
3D scan or a PET scan?

And if we find some abnormality that is highly suspicious based on the radiology data,

then we have to biopsy at the time of biopsy for a variety of reasons.

First reason is we want to confirm that this is indeed metastatic breast cancer or is this another malignancy.

And also we need to test for all those markers that doctor Mcgillian has mentioned,

you know the estrogen receptor.
her two receptors and also additional molecular biomarkers that we use these days for metastatic disease. Another issue with the metastasis is that bone metastases are usually seen in estrogen receptor positive patients, whereas brain metastases are more common in her two positive or triple negative patients. And anytime a patient is diagnosed with metastatic disease these days, we have a lot of choices and we have a lot of treatments, additional treatments that can be very helpful and they are still trying to convert.
This into a chronic disease rather than a death sentence and then we have to assess the patient for distress, which requires a lot of help on part of medical providers as well as home providers. So we all know and that’s why we have gathered today that best care for any patient is good collaboration between a primary care and an oncologist, which we do this all the time and I’ve had the pleasure of doing this with Jill for a number of years. So acute toxicity usually is taken care of by medical oncology, but chronic toxicities are shared.
between primary care and medical oncologist and any woman who has been treated with endocrine therapy, especially the aromatase inhibitors. We know about bone health, we discuss those issues and many of these patients are placed prophylactically on bisphosphonates, which is an agent that also helps with bone health but may decrease the risk of disease recurrence in the bones. We all know about the side effects of adriamycin. We do not usually reach that dosage that causes problems with the heart,
but we usually still check it.

In the adjuvant setting, anti herto therapy has a potential for cardiac complications also, but most of those issues are temporary and they resolved with discontinuation of therapy.

We have a excellent cardio oncology program that actually helps us out in care of these patients in some decision making process, whether to treat or not to treat.

Pneumonitis is another risk that can happen with chemotherapy that can happen with radiation therapy that is happening these days with
Immune therapy also.

It’s relatively uncommon but has but may require steroid therapy at some point.

Neuropathy is one of the most common chronic side effects that we hear about most commonly in breast cancer patients. Taxol is the is the culprit, although in other malignancies oxaliplatin is more notorious for that side effect. There are certain medications that actually help with some symptoms. We actually have a physical therapy department that actually focuses on neuropathy and has been really successful in helping out with this.
Chronic. NOTE Confidence: 0.77942646
Problem. NOTE Confidence: 0.77942646
Psychological health is very important in any breast cancer or any cancer survivor. NOTE Confidence: 0.77942646
And with time as we have improved on chemotherapy, we have improved on side effects, we have tried to cut back on surgeries, the financial toxicity continues to increase because of the increased cost of treatment and increased cost of taking care of these patients. NOTE Confidence: 0.77942646
So coming back to your first question, how often this person should be followed.
if they do not have metastatic disease?

Normally speaking the NCCN guidelines. Say that we need to see the patients one, one to four times a year per year for five years and decreasing frequency again based on their risk and again based on their symptoms also. We are actually working on a long term care plan at the Hill Spyro Center, trying to see what is the best way to transition back to primary care after five years and what type of patient should that be. And based on their original
pathology as well as need for continuing care, patients also need periodic screening for family history genetic testing because the genetic testing also can change in a number of years and new additional. Testing may be required. We are all familiar with the lymphedema management, which is which can be a problem, but those problems are decreasing, thankfully, to less invasive surgery, and we have good physical therapists that are available for therapists that are available for those management of lymphedema. Again, the one of the required radiology
00:42:39.848 --> 00:42:42.126 is the yearly mammogram unless

00:42:42.126 --> 00:42:45.760 patient has had bilateral mastectomy.

00:42:45.760 --> 00:42:47.645 There’s actually no indication for

00:42:47.645 --> 00:42:49.975 any other testing for routine testing

00:42:49.975 --> 00:42:52.614 in the absence of clinical signs and

00:42:52.614 --> 00:42:54.380 symptoms suggestive of a recurrence.

00:42:54.380 --> 00:42:57.138 And again we have good long term

00:42:57.138 --> 00:43:02.816 care plans that we are working on

00:43:02.816 --> 00:43:05.168 and we have a lot of these support

00:43:05.168 --> 00:43:06.916 services that are available at

00:43:06.920 --> 00:43:08.859 I will not go into individual details,

00:43:08.860 --> 00:43:11.080 but all of them are providing

00:43:11.080 --> 00:43:11.820 additional help.

00:43:11.820 --> 00:43:13.710 We have the extended care clinic for

NOTE Confidence: 0.863473149230769
off hours so that the patient cannot. Should not go to the emergency room and can go and can bypass the emergency room. We have the multidisciplinary care that we are trying to get patient an appointment together with the surgeon and medical oncologist and radiation oncologist and other supportive. Agencies, we are trying to also get next day access, which we have been successful to some extent. And then I want to mention that the oncology pharmacy has been one of the mainstays that are available in most of our offices that are readily available to discuss interactions.
and discuss any changes as needed.

And thank you very much.

With terrific, I'm going to just leave a question and answer session, although we don’t have anybody that’s offered any question and answers through our zoom connection. So if you are thinking of asking the question by all means put it in the Q&A and otherwise I have a couple of kind of logistic questions. So.

The first thing was in a cancer survivor, a breast cancer survivor who has some new symptoms, whether it’s back pain or maybe a lump,
they feel subcutaneous lump.

Is, you know,

you said to assess their risk of recurrence based on their initial cancer and that is one thing that can really stump us in primary care.

what I find is whenever I see the name of the oncologist who treated the patient, and I recognized the name, and I pick up the phone, they have this encyclopedic knowledge of exactly what means what as far as what they were treated with, and, you know, their markers. And so I'm, I'm wondering is,
is that something that’s going to be addressed in this care plan or is that kind of just the right thing to do is to pick up the phone and call an oncologist, how should we proceed when we do suspect at late recurrence or of cancer? I Karen, it’s a great question. Why did you go ahead. Sorry, go ahead. I basically you know I would say that you know picking up the phone is always very helpful that’s it’s the best care possible for the patient and again I’ve
known Jill and her group for a long time and I get these calls all the time and I think that really improves the care that directs which test needs to be done and which, there are and we are actually in a better position in a sense. To tell as to what tests should be done first. That sometimes saves money and as well as unnecessary tests also and unnecessary anxiety. Also looking at certain person, certain patient, we look at a certain abnormality, we will say you know it’s highly unlikely
related to breast cancer and that may alleviate the anxiety right away.

Yeah and I would echo exactly that, that same sentiment it’s we love to hear from primary care doctors. You know we recognize that we’re not up to date on the latest and greatest antihypertensives and I can’t name anti diabetes medications except for metformin. So the Umm it really has to be a collaboration that we do come across any number of patients.

Let’s say I had cancer. My shoulder hurts.
I need all the scans and so it's a careful balance of what that patient’s underlying risk is, which really is our job, and what’s the likelihood that this represents a metastatic or neoplastic process. And the thing that I find to be helpful when explaining to patients at least, is cancer. Usually if cancer is going to come back, it’s going to meet the three P’s, it’s going to be a symptom. That’s perplexing. You don’t know why you have it. You didn’t just shovel your
drive for three hours the day before.

It’s persistent.

It’s there, it doesn’t go away and it’s progressive and it’s getting worse.

And so those are the three things that kind of help us determine what we need to be more worried about.

We’re not going to worry about something if it’s been there for an hour and a half.

We’re going to worry about something if it’s been there for weeks and it really isn’t behaving like it should if this were some
other non neoplastic process and

then deciding what test is best.

To do really does kind of require

a knowledge about the biology

of the cancer and where is this

most likely to show up.

Some subtypes are more likely to

actually show up in the brain and

and we have to have that’s that’s

kind of our job to to catch that.

So we love to hear from

primary care doctors.

And what if I don’t know

who the oncologist is?

Or was the patients moved from out of state?

Or perhaps the oncologist has retired?
Is there a Kawaji Kawaji?

Going out to all of our New Haven clinicians,

you’ve got it all right.

That is excellent now.

We’re always happy to help.

All on in basket we’re all on my chart and happy to to take a look and we may not be able to give you the right answer, but we’re especially if we don’t have all the information but that’s not a reason we have long-term people kind of assess their underlying risk.

Thank you and that is again it
is so helpful to say to a patient

you know I’m not concerned that

this cancer that this represents

recurrent cancer and I also spoke.

To your oncologist and they share that

it actually is incredibly helpful.

So thank you for that collaboration.

Looks like we don’t have other questions.

So Jill, maybe you have a

question I was going

to ask just because in talking about

survivorship or even in the process,

it is very anxiety provoking and we

are often called upon to prescribe

anti anxiety meds or antidepressants.

And if you could just comment if
you have your preferred, if you,

if there's certain SSRI's that you prefer, certain ones you want us to avoid,

if you could maybe discuss that, that would be great. Sure.

So it some of it depends on what the patient is actually taking.

Tamoxifen has some theoretical interactions with certain SSRI's such as paroxetine, sertraline, fluoxetine kind of all of the gotos it they can. They are sip 2D6 inhibitors which can inhibit tamoxifen’s forming its active metabolite which is called.
00:50:06.090 --> 00:50:07.593 Oxygen little CME.
NOTE Confidence: 0.825934471538462
00:50:07.593 --> 00:50:10.098 Not that anyone actually cares
NOTE Confidence: 0.825934471538462
00:50:10.098 --> 00:50:14.079 but the the so we try not to Co
NOTE Confidence: 0.825934471538462
00:50:14.079 --> 00:50:15.856 prescribe those however venlafaxine
NOTE Confidence: 0.825934471538462
00:50:15.856 --> 00:50:19.448 so the SNR I and I use citalopram.
NOTE Confidence: 0.825934471538462
00:50:19.450 --> 00:50:21.315 Mrs Citalopram if you’re really
NOTE Confidence: 0.825934471538462
00:50:21.315 --> 00:50:23.555 looking looking for an Sr those
NOTE Confidence: 0.825934471538462
00:50:23.555 --> 00:50:25.662 are good go TOS that don’t have
NOTE Confidence: 0.825934471538462
00:50:25.662 --> 00:50:27.780 the same degree of interaction.
NOTE Confidence: 0.825934471538462
00:50:27.780 --> 00:50:30.450 There are no interactions for aromatase
NOTE Confidence: 0.825934471538462
00:50:30.450 --> 00:50:32.720 inhibitors that we worry about.
NOTE Confidence: 0.825934471538462
00:50:32.720 --> 00:50:34.430 Umm.
NOTE Confidence: 0.825934471538462
00:50:34.430 --> 00:50:35.084 You know,
NOTE Confidence: 0.825934471538462
00:50:35.084 --> 00:50:38.796 the the question of benzos is always one
NOTE Confidence: 0.825934471538462
00:50:38.796 --> 00:50:42.981 that we we try to minimize as much as we can.
NOTE Confidence: 0.825934471538462
00:50:42.990 --> 00:50:44.054 We can use it as a bridge,
especially around diagnosis when we're just kind of in this very high anxiety time, but I generally do not favor long term use of benzodiazepines. Agreed. Thank you. Yeah. No, and that's really what I wanted to get to the choir. For sure there is psycho oncologists that are hard to get, but they are available and they are very helpful. And I think it's, again,
The best thing is to have the good interaction between the primary care and the oncologist and that is very helpful when you are helping us take care of the anxiety parts. You know, that’s very helpful.

One of my personal favorite opportunities is when a patient comes to me for a second opinion on whether they should continue an aromatase inhibitor. They hurt all over while actually they hurt all over while actually

So I simply go back to the note and and

very often it’s actually outlined like the risk of recurrence with this medicine,
the risk of recurrence without this medicine.

It’s part of the counseling that you do is often documented and and it’s enormously helpful to me. As I explore the patient’s thinking, obviously I’m not going to give a clear directive for that, but I don’t know if you have hints for us in management of some of the symptoms so that people can continue to take it. Are there anything that you would like us to know about that? Any question?

So exercise is actually one of the things, so musculoskeletal complaints,
arthralgias related to aromatase inhibitors is a very common side effect, probably 30 to 50% experience some degree, not necessarily the severe amount, but some degree and exercise, weight bearing exercise has so many benefits just from cardiovascular risk and from bone density standpoints that in addition to. Being shown in clinical trials to produce aromatase inhibitor induced musculoskeletal complaints is incredibly helpful. Other things acupuncture has been shown to be helpful. And duloxetine has been shown to be helpful and that’s in phase three.
00:53:05.537 --> 00:53:08.920 clinical trials placebo-controlled.
00:53:08.920 --> 00:53:12.748 Those are the most kind of.
00:53:14.990 --> 00:53:20.255 Studied ways, but there are other
00:53:20.255 --> 00:53:24.807 things that that Waji and I can
00:53:24.810 --> 00:53:26.115 Sometimes switching helps,
00:53:26.115 --> 00:53:29.160 sometimes taking a break to figure out
00:53:29.236 --> 00:53:31.644 is it really the AI that’s doing it?
00:53:31.650 --> 00:53:34.210 Sometimes switching to tamoxifen,
00:53:34.210 --> 00:53:36.770 which has fewer musculoskeletal
00:53:36.770 --> 00:53:39.090 complaints and all of that,
00:53:39.090 --> 00:53:41.466 that conversation really does need to
00:53:41.466 --> 00:53:43.410 include what’s the underlying risk?
00:53:43.410 --> 00:53:44.554 Is this somebody who’s.
Incredibly high risk that we want to give the absolute fully loaded endocrine therapy for as long as we possibly can. Or is this somebody with a very low risk cancer where the difference between 2 endocrine therapy strategies is probably minimal and a month off is not going to make a big deal? If you elicit that history, it’s we love getting those kind of heads up. And so is really having a tough time. And we can certainly explore options and sometimes people just can’t tolerate it.
It happens and you have to do the risks and benefits and it’s our job to make sure that we understand all of the benefits and it’s up to the patient to decide whether or not it’s something that they can tolerate and many people can’t.

Good. I like that permission not to tolerate understanding risks. It’s exactly right. It’s it’s, you know, we just have to explore it and make sure it’s an informed decision.

So we are drawing to the end of our hour. I’ll ask one final question, which is, is there anything you just really
wish the primary care clinicians knew in our relationship with you? And then I’m going to ask Jill if there’s anything she really wishes that her oncology team knew for referrals? I think we’ve already hit on. Probably my favorite thing, which is pick up the phone, send me a my chart, I’ll give you my cell phone number. The we want to be involved, especially when it comes to more advanced stages when people have metastatic disease, goals of care, conversation, prognosis.
We really do try very hard to to explore those with our patients and and document it, but we want to be involved with all. Decisions and sometimes it may make sense not to be doing evidence based primary healthcare maintenance in patients who have advanced cancer and we're happy to to talk about it. But then in other cases, it may make sense for somebody to have a colonoscopy even if they have metastatic breast cancer. We love to participate in those conversations. Absolutely. You know, yes,
it’s good to have a good connection.
That’s very important.
It’s very helpful honestly and it’s very helpful also for non oncologic care to be good also.
So that’s why we definitely need you and we need primary care physicians to be deeply involved in the care of patients.
All right. And Jill, your perspective and then we will. I think I agree with everything that’s been said and I think just knowing that our oncology colleagues are ready and willing to pick up the phone for us and we’re willing to pick up the
00:56:50.880 --> 00:56:53.181 phone for them to allay a patient’s fears because there are times when,
00:56:55.450 --> 00:56:57.475 you know, we get asked what is the unco.
00:56:59.540 --> 00:57:01.857 My number, what is the number mean?
00:57:01.860 --> 00:57:04.302 You know those kinds of conversations that are sort of beyond our expertise,
00:57:07.590 --> 00:57:09.252 but that we can be helpful in other ways. So thank you.
00:57:11.280 --> 00:57:14.432 you. All right. So thank you to all of you and to everybody who attended.
00:57:18.130 --> 00:57:21.630 This has been a very helpful conversation. Please stay tuned for a few final seconds because there is one more slide that is a kind of very quick.
00:57:24.948 --> 00:57:27.094 Evaluation and completing that
00:57:30.606 --> 00:57:32.676 is helpful for the series.
NOTE Confidence: 0.835538238
00:57:32.680 --> 00:57:34.955 And do you have any closing comments?
NOTE Confidence: 0.835538238
00:57:34.960 --> 00:57:36.288 No, this is terrific.
NOTE Confidence: 0.860805636666667
00:57:37.400 --> 00:57:38.880 The contacts are there.
NOTE Confidence: 0.860805636666667
00:57:38.880 --> 00:57:40.730 And then once this closes,
NOTE Confidence: 0.860805636666667
00:57:40.730 --> 00:57:42.370 you’ll get a survey.
NOTE Confidence: 0.860805636666667
00:57:42.370 --> 00:57:44.938 If you could, if you could fill that out,
NOTE Confidence: 0.860805636666667
00:57:44.940 --> 00:57:45.960 that’d be helpful for us.
NOTE Confidence: 0.860805636666667
00:57:45.960 --> 00:57:49.584 And and tell your friends we we have
NOTE Confidence: 0.860805636666667
00:57:49.584 --> 00:57:52.574 one for next week or next month and
NOTE Confidence: 0.860805636666667
00:57:52.574 --> 00:57:54.759 actually we’re scheduled throughout June.
NOTE Confidence: 0.860805636666667
00:57:54.760 --> 00:57:55.876 So if you enjoyed this today,
NOTE Confidence: 0.860805636666667
00:57:55.880 --> 00:57:56.628 just let us know.
NOTE Confidence: 0.860805636666667
00:57:56.628 --> 00:57:57.376 That would be helpful.
NOTE Confidence: 0.860805636666667
00:57:57.380 --> 00:57:59.550 Thanks so much everybody and.
NOTE Confidence: 0.860805636666667
00:57:59.550 --> 00:58:01.300 Happy Breast Cancer Awareness Month.
00:58:01.860 --> 00:58:03.000 Thank you.