Welcome to Yale Cancer Answers with your host doctor Anees Chagpar, Yale Cancer Answers features the latest information on cancer care by welcoming oncologists and specialists who are on the forefront of the battle to fight cancer. This week, it’s a conversation about treating breast cancer patients during the pandemic with Doctor Elizabeth Berger.

Doctor Berger is an assistant professor of surgery and oncology at the Yale School of Medicine, where Doctor Chagpar is a professor of surgery.

Elizabeth maybe you can start off by telling us a little bit about yourself and your background and what exactly you do.

I’d be happy too. I hail from Chicago, a Midwesterner through and through I’m a Midwesterner through and through and did a lot of my surgical training at Loyola University in Chicago and decided
That during my general surgery residency, I wanted to specialize in breast cancer surgery. And I was fortunate enough to head out to New York City to do my training at Memorial Sloan Kettering in breast cancer surgery.

As you guys all know this trying has been a trying year for us and Covid was a big part of my fellowship training year, but during that time I got to explore many different parts of breast cancer, learn a lot about breast cancer and now I’m excited to join the faculty at Yale University where I just recently became an assistant professor. Elizabeth, one of the things that has often intrigued me is, what was the covid pandemic like for people training in various parts of medicine and surgery, you must have been a little bit past midway through your fellowship when the pandemic struck. And what was that like in terms of your training and in terms of treating breast cancer patients? That’s a great question.
I vividly remember early to mid February hearing about this and what we thought was just another flu from China and thinking that it might affect things we were doing, but maybe not much. And I was quickly proven wrong and by early March when we essentially shut down most of what we were doing with regards to elective surgeries and even with regards to a lot of cancer operations at Memorial, I can say that our volume dropped by about 80%. I know that many New York City hospitals were incredibly hard hit with taking care of Covid patients. And the majority of their elective surgeries and even maybe not so elective surgeries stopped. We at Memorial had a little bit different experience. We still had a high number of combinations in our ICU’s and honor floors, but we don’t have an ER so we don’t take any kind of person off the street, but we did take care of a lot of our own patients, which greatly affected my
experience as a fellow. Our case volume dropped, our in person conferences stopped. We went all to virtual. We weren’t allowed to travel to any academic conferences anymore. We were constantly updated about possibly getting reallocated to help in the ICU’s or to help on the floor or to help in our urgent care. It seems like every week was different. It was constantly changing, constantly evolving. I will say I felt so fortunate to be at a place where we have such a high volume of Breast Cancer Care because I was still able to actively engage in learning about breast cancer and taking care of breast cancer patients who needed operations during this time. It’s hard to tell a breast cancer patient that we can’t operate on them, so we definitely triaged. We made decisions based upon who really needed an operation during this time and most patients in the NYC area were quite frightened, so that was a whole other aspect of
training and going through fellowship during the pandemic, where the uncertainty for the patients was almost worse than for the uncertainty for our health care providers. I also actually had the experience interestingly enough, of helping out another facility. with taking care of Covid patients and that was probably the most dramatic and tough experience, medically, for me, ever. Tell us more about that. There was a call from our governor for healthcare providers throughout the state and really the country that if we were available to help that they would call upon us and I felt that my responsibility was absolutely to my breast cancer patients and I continue to commit myself to my breast cancer patients. But I was able to work a few times in a community hospital trying to help. What was that like in terms of, I can imagine that you’re being torn in two directions. On the one hand, you want to help the greater society in this pandemic, and all of these covid patients,
which really you know, took over many New York hospitals.
And on the other hand you’re taking care of breast cancer patients who are particularly vulnerable.
Often times with compromised immune system, if they’ve already had chemotherapy and you know the potential of being a carrier of a highly contagious virus between one environment and the other.
How did you navigate that and what was that like?
I was fortunate to be in a situation where we were tested essentially weekly.
We had the option of being tested weekly and then as the pandemic continued to evolve that weekly testing went to every two week testing,
but suffice it to say, as the pandemic evolved we got busier with our surgical volume at Memorial and again my attention turned back to mainly my breast cancer patients,
it is a emotional time as a health care provider to think that as an asymptomatic carrier you could unfortunately be exposing yourself to immunocompromised cancer patients,
which is why I felt very fortunate to be in a situation where I
could get tested very frequently
to have the reassurance that
I had negative tests.
And of course I took all the
other precautions that we possibly
could, wearing masks,
making sure we’re doing our hand washing,
making sure we are socially distancing.
We obviously took our significant precautions
with our cancer patients coming in alone,
not allowing visitors, testing the
patients before they underwent
surgery so multiple different layers
of precautions to try to avoid
any kind of exposures to our patients
and to our health care providers.
Did patients ask you about whether
you had been treating Covid patients
and was that of concern to them?
Or were they more concerned with getting
their cancer taken care of because
they knew that many patients were being
defered?
I think there was fear of
the unknown of just what exactly the
pandemic was doing and could do
and how sick it could make people.
I think there was fear of coming into
a hospital, which is why many of
our patients did choose to defer if
they were eligible to defer surgery. I think there’s a lot of fear about not getting their cancer treated, so that was another topic of conversation. And of course, there’s fear from every healthcare provider just working in a hospital of being exposed to Covid positive patients and then taking care of other patients. So I think we tried as best we could to alleviate the fears that we knew how to control and unfortunately there were some things out of our control, but again, I think we try to do as much as we possibly could to control what we could control. Yeah, I think that that’s so true for many patients. It was really a matter of being stuck between a rock and a hard place in a lot of ways. On the one hand, I’ve got this cancer and I’ve had my surgery scheduled and I want the cancer out because it’s a cancer. And on the other hand, I don’t want to get covid and I know that I’m going to be exposed even at a cancer hospital like you say at Memorial, where the majority
of the patients have cancer, but there still were Covid patients. So how did you have that conversation with patients and how did you and the patients decide whether to go with the rock or whether to go with the hard place. I think in presenting the options to patients and giving them as much data and science behind the options was incredibly important. We had patients who had early stage disease, or DCIS, so stage zero or pre invasive depending upon how you define that where I think the conversation we had was that these cancers will not change drastically in the next six months, and we can treat them with systemic hormonal therapy in the interim, as we continue to navigate the pandemic and understand it better in the next six months. And so we have that time on our side and we have that option. And I think patients really appreciated the conversation of explaining the neoadjuvant treatment options for early stage disease, the kind of hard place where patients who had already gone through neoadjuvant chemotherapy who needed an operation or who had worst disease that maybe didn’t
have the time option on their side, and so that was, I think, a harder conversation at times because patients were very worried about their cancer. Very worried about Covid and like you said, there wasn’t really a great option either way, but I think with our ability to operate on a lot of our patients in ambulatory surgery center where no Covid patients were actually housed, gave patients a lot of comfort. I think knowing that health care providers were getting tested frequently that the patient before having surgery was going to get tested. Give as much comfort as we possibly could to patients who did need to go through that hard place choice by coming in and having surgery. In the patients who had more advanced disease, we often even outside of Covid, would say take systemic chemotherapy, do your neoadjuvant chemotherapy and then will operate later. And as you say, for the early stage cancers,
the particularly indolent ones, especially if their hormone receptor positive, we know that these can be well treated with endocrine therapy, and you can buy yourself some time where the issue really came in for us here and I think this is true around the country as well were in those patients who you’re up against a time jam because when you treat patients in the neoadjuvant setting you give them chemotherapy upfront for what is usually an advanced cancer you want to operate within a certain time window. What I often called the sweet spot, that 4 to 6 weeks after their last dose and when that timing which they’ve been waiting for the last four to six months, happens right during the pandemic, that puts everybody in a tough spot. We’re going to talk more about the treatment of patients during Covid and how that may have changed in lessons learned right after we take a short break for a medical minute. Please stay tuned to learn more information about breast cancer surgery and outcomes with my guest doctor Elizabeth Berger. Support for Yale Cancer Answers
0:14:44.495 -> 0:14:46.707 comes from AstraZeneca, a global biopharmaceutical company with a robust oncology pipeline and FDA approved therapies in lung, ovarian, pancreatic, breast, and blood cancers. Learn more at astrazeneca-us.com.

0:15:01.6 -> 0:15:03.665 This is a medical minute about pancreatic cancer, which represents about 3% of all cancers and about 7% of cancer deaths. Clinical trials are currently being offered at Federally designated comprehensive Cancer Centers for the treatment of advanced stage and metastatic pancreatic cancer using chemotherapy Folfinrix, a combination of five different chemotherapies is the latest advance in the treatment of metastatic pancreatic cancer and research continues in centers around the world looking into targeted therapies.

0:15:38.185 -> 0:15:41.093 A recently discovered marker HENT one. This is been a medical minute brought to you as a public service by Yale Cancer Center. More information is available at yalecancercenter.org. You’re listening to Connecticut Public Radio.

0:15:51.83 -> 0:15:52.23 Welcome
This is doctor in Anees Chagpar. I'm joined tonight by my guest Doctor Elizabeth Berger and we're talking about breast cancer surgery and outcomes, and right before the break we were talking about breast cancer, particularly in the era of Covid.

So Elizabeth, you were mentioning that with some of the early stage cancers you would have the conversation, this is really quite an indolent disease. It's hormone receptor positive, you can be well treated with endocrine therapy, but prior to Covid, those were patients that we often would operate on first. So if you really thought about the lessons learned from Covid in terms of changing paradigms that we once thought were fixed in stone and do you think that we've become a little bit more liberal about how we time various modalities of treatment? That's a great question. I think the avenue of neoadjuvant therapy had has been an
amazing option for, like you said, these early stage indolent patients because of the Covid era. I know that in Europe actually they use neoadjuvant endocrine therapy a lot more than we have in the past. But I think it’s going to open many avenues in the future to one study this more and understand neoadjuvant endocrine therapy better for our patients and to absolutely give people the option. I think the tricky part of neoadjuvant endocrine therapy are a couple things. One is duration of therapy. We obviously put our patients on therapy after they have surgery for anywhere between 5 to 10 years depending upon many factors. So in the neoadjuvant setting in the setting before surgery, you know I’m not sure that we’ve all come to a consensus as to what is the optimal time for neoadjuvant endocrine therapy and in addition, I think there’s still some questions about the management of the auxilia after neoadjuvant endocrine therapy, and really, how we think about treating the auxilia.
after neoadjuvant endocrine therapy.

So I see it now as we now have a wealth of knowledge, and experience of patients who receive neoadjuvant endocrine therapy in the Covid era.

I think, continue to receive neoadjuvant endocrine therapy, and I think we'll just have more data moving forward, which will only benefit our patients and us.

Yeah, I think that that's so true. I think that we've really started to have a little bit more flexibility in terms of, you know, the discussions that we have with patients in terms of therapeutic options.

The other thing that I noticed and I'd like to get your sense of this as well, was that even surgical options during Covid were changed a little bit, we ended up not offering patients the huge reconstructions in the immediate setting that would require a prolonged hospital stay and so on which we had done all the time prior to Covid. Just because these patients may or may not require ICU they may require several
days in hospital.

And we really wanted to make sure that if they required surgery they were getting in and out of the hospital as quickly as possible to minimize their risk in terms of the virus, was that the same in your experience at Memorial as well? Yes, I think that was a big component of breast cancer care that we were not delivering was big, autologous reconstruction, so you know there was no option for autologous reconstruction during the worst of the pandemic and just as a caveat, changing so much week to week. I don’t want to make broad generalizations, but when I say the height of the pandemic, March April, May, we really limited even implant or tissue expander reconstruction. That was pretty much halted as well, because if you think about the need for expansion and such after the operation that had required would require a lot of contact in and out of the office. So we really tried to not do any of that kind of reconstruction. We also stopped prophylactic surgery. A lot of our patients come
with genetic mutations. They come in wanting a prophylactic contralateral mastectomy. And that really was something that we did not offer during the height of the pandemic thinking it was something that we could safely delay. It's you know 6 to 8 months and then any high risk lesion that those operations that we also stopped. So as you stopped autologous reconstruction, you stopped the prophylactic surgery for genetic mutation carriers, contralateral prophylactic mastectomies and so on. Pre Covid these were things that patients demanded and we know that the Women’s Health Act, for example, mandates that private insurers must cover reconstruction as part of a cancer operation because it makes women feel whole. So how did you kind of square that in your own mind? Did you feel that we were delivering suboptimal care. Did patients embrace the idea that we were trying to do? It was in their best interest in
terms of minimizing risk to the virus, or did some of them feel like they were really shafted in terms of the timing because they really wanted that reconstruction or wanted that prophylactic mastectomy? I’m sure everyone had their own thoughts and opinions on it. I think it’s hard to say general consensus, but I would say that most were either understanding or were quite scared of the pandemic and so whatever motivated them to understand that they couldn’t undergo maybe the prophylactic side that they wanted or the have the reconstruction that they wanted. I honestly didn’t feel as though those conversations were that difficult and what I would like to also believe is, a lot of it was for the greater good of society. In New York City we were struggling with resources we were struggling with ventilators we were struggling with space in hospitals. I think a lot of patients recognized that and understood that at this point we really needed to save resources or protect resources.
that we needed for really sick Covid patients and that it wasn’t that we were saying no forever. We were just saying we need to temporarily delay because of the magnitude of the healthcare strain during the pandemic. I think that’s so right. I think that you know, yes, that does mean a second operation in the future. Yes, we would have preferred to do everything at all at once. Yes, we would have liked to have given you the reconstruction that you would have liked, but I really do think that you know, for all of its negatives, one thing that the pandemic did do for many of us was really kind of bind us together in a common humanity. Where we really were going through this all together and one of the things that struck me was how people really did get this concept of, you know, I need to do my part for society, which is something that I don’t think we always see. I agree, I think it was challenging times for all individuals. I can’t imagine what cancer patients were going through at that time.
Knowing myself

who was, you know, a healthy young

person being scared at times so

I think understanding that like you said,

we’re all in this together.

Experiencing our own different stressors and

situations and doing the best that we could.

I think that’s really the message

that we tried to send

our patients, our colleagues.

And I think the other question now is,

we’re still not

out of the woods yet.

But as we start to vaguely see a glimmer

of light at the end of the tunnel,

many patients had delayed not

only their surgical care in terms of

reconstruction or prophylactic mastectomy,

many patients had actually delayed

getting their usual screening

mammography because many of them,

the imaging facilities,

had also shut down, and so on,

and so now, what is your anticipation?

Do you anticipate that we’re going

to have like this huge influx of

cancer patients who haven’t

had a mammogram in the last six

months and they are now getting

their mammograms and finding things?

People who hadn’t had their
Do you kind of anticipate a wave of breast cancers now and what’s the system doing to prepare itself for that? I read somewhere recently that people were very worried about obviously cancer patients coming back with more advanced stages because of lack of screening colon cancer people not getting their colonoscopies, breast cancer, not getting their mammograms. And, you know, I actually asked a lot of people I was working with in New York City what their opinions were and I know I personally feel that we absolutely will see probably an uptick in terms of patients coming in now I think the bigger question it begs to be asked is are those patients coming in going to have more advanced disease? I think you know mammography does such a good job at catching cancers early, and you know if a woman felt a lump, I think there was still access to get imaging during the pandemic. If there was any kind of symptom or concern in a woman's breast,
0:28:30.9 –> 0:28:35.36 so I think the verdict is still out.

0:28:35.36 –> 0:28:39.176 It’s really hard to say what we’re going
0:28:39.176 –> 0:28:43.383 to see now in the next 6 to 12 months.

0:28:43.39 –> 0:28:46.604 In terms of more cancers, worst cancers.

0:28:46.604 –> 0:28:50.54 But I do think there still is probably
0:28:50.636 –> 0:28:53.366 a lot of high risk lesions that
0:28:53.366 –> 0:28:55.929 need to be taken care of.

0:28:58.38 –> 0:29:00.17 Maybe patients who didn’t get
0:29:00.17 –> 0:29:01.602 reconstructed coming back in

0:29:01.602 –> 0:29:03.428 and wanting reconstruction or

0:29:03.428 –> 0:29:05.308 contralateral surgery and such.

0:29:05.31 –> 0:29:06.13 Doctor Elizabeth

0:29:06.13 –> 0:29:08.18 Berger is an assistant professor

0:29:08.18 –> 0:29:10.23 of surgery and oncology at

0:29:10.303 –> 0:29:12.248 the Yale School of Medicine.

0:29:12.25 –> 0:29:13.886 If you have questions,

0:29:13.886 –> 0:29:15.522 the address is canceranswers@yale.edu

0:29:15.522 –> 0:29:17.782 and past editions of the program

0:29:17.782 –> 0:29:19.846 are available in audio and written


0:29:21.63 –> 0:29:24.534 We hope you’ll join us next week to

0:29:24.534 –> 0:29:27.787 learn more about the fight against cancer.

0:29:27.79 –> 0:29:30.885 Here on Connecticut public radio.