Support for Yale Cancer Answers comes from AstraZeneca, dedicated to advancing options and providing hope for people living with cancer. More information at astrazeneca-us.com. 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 patient perspective on cancer treatment during the pandemic with Christina Allen and Doctor Tara Sanft. Christina is a cancer survivor and doctor Sanft is an associate professor of medicine and medical oncology at the Yale School of Medicine where Doctor Chagpar is a professor of surgical oncology. Let’s start with you Christina, tell us a little bit about your story. Sure, thanks so I was 38 years old at the time of my diagnosis and I have a diagnosis of locally advanced breast cancer. I was not experiencing any symptoms prior to my diagnosis and like so many other people I did not have a family history of breast cancer either. So the cancer was found after
I felt a small lump, which I initially thought was a bug bite. It was over the summer, this past July I had been swimming and really thought not much of it until the following morning when I woke up and it was still there and felt almost like a little pebble under the surface. And at that point it was a bit of a freeze moment, OK do I do something about this? What do I do? So I reached out and was able to see my OBGYN within a day or two. At which point she had referred me for further imaging, and that’s when I became connected to Smilow. I think another important thing to mention is that throughout my treatment and my illness, I have continued working and I am a licensed clinical social worker in healthcare and have been working in hospital systems for a little over 12 years now. So Christina you were diagnosed, I mean this really happened this past July, July of 2020, right in the middle of this pandemic. Talk to us a little bit about, you kind of mentioned this,
Oh my gosh, what am I going to do moment, I can only imagine that that was even heightened with what am I going to do in the midst of Covid? Is my doctors office open? Do I do a virtual visit? Do I go into the office? How does that work? Tell us a little bit about that thought process and whether you ended up seeing your doctor using telemedicine, or whether you went into their office and whether you had any challenges with that. That’s a great question. Almost right from the beginning, covid sort of felt like this parallel opponent in my treatment and in my illness it was always a consideration, always a factor in the decisions that I was making and the decisions that my treatment team has been making. I knew that getting in for a clinical breast exam was going to be the next step after I felt that lump, so I was pretty specific and persistent with asking for an in person visit with my OBGYN and I really love the flexibility that has come out of covid and the increased availability of telemedicine,
but you know some things just have to be done in person and I knew that I wouldn’t feel comfortable at that point using a telemedicine visit, so I was able to get the in person visit and then there was a bit of a struggle and delay with trying to get imaging going because my understanding is that a lot of imaging centers had decreased capacity or maybe even temporarily closed. So I did have to advocate for myself to get that imaging done and to be very clear that this was not routine screening, although that should not be deferred either, but rather that this imaging was diagnostic and those days I mean I can remember the seconds, minutes, hours and days between visiting my OBGYN and getting confirmation that yes, this is cancer. That was a really really difficult time. Tara maybe I’ll bring you in here, you know, during the pandemic talk a little bit about how as a health care provider and as a chief patient quality officer, things kind of shifted during the pandemic.
What were the approaches in terms of clinic visits in terms of imaging? How did facilities shift and what ramifications do you think that had?

I feel like in recalling and listening to Christina’s story, it brings me back. I’m also a breast cancer oncologist, so I treat patients with breast cancer, and I vividly remember the process of going through a national shutdown and talking to many institutions on how they’re handling it. And then I remember the Yale response and I have to say that with the guidance of the CDC, we did everything we could to keep our patients safe.

As a provider, I was in clinic, 2 1/2 days a week, most weeks, and then we went through a complete shutdown where we really minimized in person visits because of the virus and really tried to focus on the patients who were receiving in person IV chemotherapy.

And so you know, patients like Christina coming through, we really stressed over what to
do about patients with suspicious findings or needing diagnostic imaging. Fortunately at Yale, I think, that never stopped. There were many routine imaging that was deferred. And we’re still feeling the effects of that. Yale is a system that I have to say I thought, did a really wonderful job especially in communicating, because this was the first time for any of us to go through a pandemic and so really understanding the protocols and how things are changing everyday was paramount in our response, and as a provider I felt very well informed and I was able to convey those messages to my patients. So Christina ultimately, you were able to advocate for yourself, which I think is such a strong message for patients at large, whether there is a pandemic or no pandemic, but particularly during these times, to advocate for yourself to get the in person visit with your OBGYN to get the diagnostic imaging, and it sounds like ultimately to get the biopsy and the diagnosis. And so then what happened? After the diagnosis was confirmed,
I was referred to a medical oncologist and a breast cancer surgeon, and then shortly afterwards, my radiation oncologist, so I started to have that treatment team built up around me and I have an awesome treatment team. Doctor Tristen Park, my breast cancer surgeon, Doctor Knowlton my radiation oncologist and Doctor Kanowitz, my medical oncologist. They’ve all been wonderful, so it may sound a little strange, but once the diagnosis was confirmed, we started putting plans in place, it was a little bit less of the unknown. I’m somebody who likes to have a plan. OK, this is what we’re going to do. This is how we’re going to approach this. These are the people you can contact with questions or when you need help, so getting that ball rolling felt like a bit of a relief to me. And were those visits that you had with those providers in person as well? Some were and some weren’t, and now I’m recalling some things from earlier on, I do recall that initially when I was scheduled with my breast cancer surgeon,
it was set up as a telemedicine visit and I didn’t quite understand the rationale behind that, and was sort of wondering, is this best to meet her for the first time over Tele Medicine when she’s somebody who is going to be operating on me so I actually reached out to Doctor Park directly and asked her if she felt that that was the best thing to do clinically to meet for the first time over Tele Medicine, or if she thought it would be more beneficial to come into the office in person. She was extremely responsive, and gracious and said no, I would prefer to see you in person so she switched the visit from Tele Medicine to in person and I really appreciated that flexibility and input from her because this is not my area of expertise, I don’t know sometimes is it better to see somebody in person versus telemendicine. The risks versus benefits there. So I really had to depend a lot on the team and let them tell me what’s the better way to go. But for example,
was telemedicine and that was more or less to establish a relationship with her and for her to hear a little bit more about my history, knowing that the radiation was going to be at the tail end of my treatment and even allowed me to work almost a full day and just take an hour out to go somewhere quiet and private and do the telemedicine visit and then get back to work. So certainly, I mean, it seems like the pandemic which caused this versioning of telehealth visits might actually have been a little bit more convenient for some visits. How did you kind of think about which visit should be telemedicine, which visit should be in person. And going forward, do you think that Tele Medicine might play an increasing role, particularly when you hear stories like Christina’s where you can work the whole day and just take an hour off for the visit instead of having to take half a day off, find parking, and go through the whole rigmarole
for what might be the same visit.

Yeah, when the pandemic first started, we often didn’t have a choice. Many of our visits were converted to telemedicine again in the hopes that we weren’t exposing patients to a contagious virus in person. So a lot of our new patient visits where we would normally see them in the office were done on telemedicine in retrospect some of that was good. It was very disorienting. You know, we’re all learning new ways to take care of patients, and I think as time goes forward, the most important thing will be what Christina mentioned, which is a shared decision. Are you comfortable doing this on telemedicine? Do you feel there is a good reason to be seen and examined in person? And I think providers are learning the value of listening to those patient preferences in order to accommodate and honor what is preferred and probably what’s necessary, so patients know inside it’s OK to just do this one on video and next time in person or they know
I think I need an exam and we need to really pay attention to those preferences and honor that.

We’re going to take a short break for medical minute and then come back to learn more about Christina’s experience with cancer and the Covid vaccine right after this short break.

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This is a medical minute about Melanoma. While Melanoma accounts for only about 4% of skin cancer cases, it causes the most skin cancer deaths and when detected early, Melanoma is easily treated and highly curable. Clinical trials are currently underway to test innovative new treatments for Melanoma. The goal of the specialized programs of research excellence in skin cancer or SPORE grant is to better understand the biology of skin cancer with a focus on discovering targets that will lead to improved diagnosis and treatment. More information is available at yalecancercenter.org.

You’re listening to Connecticut Public Radio.
Welcome back to Yale Cancer Answers. This is Doctor Anees Chagpar and I’m joined tonight by my guests Christina Allen and Doctor Tara Sanft. We’re talking about Christina’s journey with cancer through Covid, and ultimately to the Covid vaccine. So Christina right before the break you were telling us how you were diagnosed right during the pandemic and you ended up having some of your visits virtually some of your visits in person. Tell us a little bit more about how the decision-making went in terms of your treatment strategy.

Sure. At the beginning everything was so overwhelming for me and I really didn’t realize just how many decisions there are to make about the treatment and about the strategy. And then what the options are. I did my best to educate myself and then of course I have to heavily rely on my treatment providers and really deeply trust them because they are the experts at treating breast cancer. I was worried all throughout that Covid would possibly delay or defer parts of my treatment, although that did not turn...
0:17:13.98 –> 0:17:17.23 out to be the case,
0:17:17.23 –> 0:17:20.48 so I was starting chemotherapy
0:17:22.73 –> 0:17:26.39 about a month after we had
0:17:26.39 –> 0:17:28.83 confirmed the cancer diagnosis,
0:17:28.83 –> 0:17:33.438 I did make a decision to receive my
0:17:33.438 –> 0:17:37.232 chemotherapy at one of the outpatient
0:17:37.232 –> 0:17:41.024 clinics for Smilow in North Haven,
0:17:41.03 –> 0:17:43.47 which was extremely convenient
0:17:43.47 –> 0:17:47.13 for me, closer to my home,
0:17:47.13 –> 0:17:51.48 and also much easier to park,
0:17:51.48 –> 0:17:56.07 to get in and out of and also just less
0:17:56.192 –> 0:18:01.136 congestion and traffic then Smilow proper.
0:18:01.14 –> 0:18:03.424 So it was really,
0:18:03.424 –> 0:18:06.85 really great to have that option
0:18:06.971 –> 0:18:10.535 to use the North Haven location
0:18:13.83 –> 0:18:16.254 And I felt very
0:18:16.254 –> 0:18:19.284 safe there the entire time.
0:18:22.63 –> 0:18:24.932 Tara, NOTE Confidence: 0.8432569
0:18:24.932 –> 0:18:27.59 did you find that in your
0:18:27.697 –> 0:18:30.737 management of breast cancer patients
0:18:30.737 –> 0:18:34.31 that you may have switched
0:18:34.31 –> 0:18:36.964 therapies or the sequencing of
0:18:36.964 –> 0:18:40.15 therapies or the location of therapies
0:18:40.15 –> 0:18:42.81 given considerations of the pandemic?
0:18:44.33 –> 0:18:47.55 Yes, we did all of those things.
0:18:47.55 –> 0:18:50.98 So fortunately we have a robust cancer network
0:18:50.98 –> 0:18:53.989 here with locations all over the state.
0:18:53.99 –> 0:18:56.29 And just as Christina got
0:18:56.29 –> 0:18:58.59 her care in North Haven,
0:18:58.59 –> 0:19:01.05 I frequently recommended my patients
be treated close to home rather than coming down to the main hospital for some period of time. And even during that time, some listeners may remember that the cancer care was temporarily moved outside of Smilow Cancer Hospital for some time, and so I even practiced at a location in Guilford for awhile while we were again minimizing people coming into the hospital. We also made modifications to the timing of some therapies and that was consensus driven, so we really spent some time listening to our leaders and colleagues across the nation. And I remember logging into many webinars where there were conversations about how to best care for patients without compromising their curative treatments, but minimizing their risk of exposure. And I think that we made the best decisions we could make at the time and it was collective. Oncology tends to work really well together for the good of the patients, and I felt that coming through the pandemic. Yeah, and so Christina you ended up getting your chemotherapy 1st and then what happened? How long after that did you embark on surgery?
I recall asking Doctor Park how soon after chemotherapy can I have my surgery and her response was four weeks would be the minimum and I think my surgery was like 4 weeks to the day that I ended chemotherapy. I was ready for the next step so there really wasn’t any disruption. The planning went pretty smoothly. I was extremely fortunate that I did not experience any delays in my chemotherapy, I was able to have the treatments as scheduled. Of course, there were side effects, but they didn’t sideline me so I finished as expected and then exactly like 30 days later I went in for surgery. And so what was that experience like? I mean you come into surgery. Were you able to bring your family? Did you have to wear a mask? when you talked about Covid being like this parallel line with your your cancer, tell us how that kind of influenced the surgical management. Sure, so masks of course at that point they were so commonplace, and familiar that it’s just what we do, right?
What was a little trickier was figuring out who can be with me? Can my husband be with me if he can? Can he stay? What does he need to do? What do I bring to the hospital with me if he can’t stay? So that was a little trickier than even right up to the day that I was being admitted for surgery it still wasn’t clear which portions he was going to be able to be there for and how long he might be able to stay for, so I think you get more comfortable, sort of living in gray areas and with the unknown when you have cancer, so that was just another something that we sort of had to roll with. It was more of, this is the bag I’m going to take if you can’t come with me. If you can come with me, I have this bigger bag that you’re going to take in with you and then there will be another backup plan if needed. So just trying to be flexible. But he was able to stay with me right up until I went over to the operating room. Tara, you know we talk about cancer so often, we talk about having a support
0:23:41.076 –> 0:23:43.49 system and how important family is
0:23:43.49 –> 0:23:45.932 and you know clearly the pandemic
0:23:46.004 –> 0:23:48.699 kind of threw a wrench into familial
0:23:48.699 –> 0:23:51.198 support where patients often
0:23:51.198 –> 0:23:53.428 will have their entire families
0:23:53.428 –> 0:23:56.415 with them at clinic visits or in
0:23:56.415 –> 0:23:58.938 the hospital room or in the waiting
0:23:58.938 –> 0:24:01.5 area for their surgeries and so on.
0:24:01.5 –> 0:24:04.356 Tell us about how that that changed
0:24:04.36 –> 0:24:06.916 with the pandemic and what adjustments,
0:24:06.92 –> 0:24:10.336 if any, were made to compensate for that?
0:24:12.07 –> 0:24:14.56 Yeah, thanks for bringing this up.
0:24:14.56 –> 0:24:17.616 I think this is one of the most
0:24:17.616 –> 0:24:20.232 painful changes that came with the
0:24:20.232 –> 0:24:22.442 pandemic because of the risks,
0:24:22.45 –> 0:24:24.52 the decision was made to
0:24:24.52 –> 0:24:26.176 limit or restrict visitors.
0:24:26.18 –> 0:24:27.84 And as you mentioned,
0:24:27.84 –> 0:24:29.5 especially in cancer care,
0:24:29.5 –> 0:24:32.776 those visitors, those loved ones are
0:24:32.776 –> 0:24:36.558 so important to every step of the way.
0:24:36.56 –> 0:24:39.087 And I think that that
0:24:39.087 –> 0:24:41.04 decision was very difficult.
0:24:41.04 –> 0:24:43.476 It was painful for everyone involved,
0:24:43.48 –> 0:24:46.329 especially the patients and their loved ones.
0:24:46.33 –> 0:24:48.801 You know, many efforts were made to
0:24:48.801 –> 0:24:51.209 try to improve the communication.
0:24:51.21 –> 0:24:53.25 Once a patient was hospitalized,
0:24:53.25 –> 0:24:53.872 for instance,
0:24:53.872 –> 0:24:56.36 we did a lot to try to ensure
0:24:56.434 –> 0:24:58.854 communication with the family member
through all different types of media, including face timing on rounds, lending iPads to each room and then we even had a system where there were volunteers who called with updates every day. I’m not sure that we did that for every patient. I know there were many patients who felt that the communication could have been better. And I think that we need to look at our processes and going forward figure out all the different ways that patients prefer to be communicated with and then try to do everything we can to spend that time doing that communication, in addition to all of this, we were avoiding going into rooms for the risk of exposing the patient and I know that was also a very isolating experience for patients hospitalized during that time. So it’s something that we will analyze and understand, how we can do better, and we continue every day to try to maximize the chances that patients and their loved ones feel informed and cared for and heard.
And so then Christina, you have your surgery and presumably you get out of the hospital. Then what happened?

So I was doing well enough that I was able to leave the hospital that evening and that was a decision that was definitely brought on by me and partially because I wasn’t able to have family with me during that time. I knew as long as my doctor felt that it was safe for me to go, I knew that it was going to be better for my healing and recovery to be around family and to be back home. So I went in that morning and I was home by like 8:00 PM that evening, but my team, Doctor Park was texting me that evening, the next day checking in on me so I still felt like I had a lot of support but had the luxury of being back home where I was going to get the best rest and have the most help from family so everything went pretty smoothly once I got home.

Did you worry about potential covid risk that your family could bring in? That would affect you, particularly?
but even during your chemotherapy.

Was that concerning for you in living with your family, who you know presumably were out in the real world? Potentially exposed to the virus and getting infected yourself?

Yes, I live with my husband and he had to make a lot of sacrifices. And think very carefully about who he was around and where did he absolutely have to go versus maybe want to go? And I really didn’t see much other family, especially prior to getting vaccinated myself and I also didn’t bring my husband into my chemotherapy treatment, even at times when it was better under control. And they said I could bring one person, and I was worried about what he could potentially be bringing into other people receiving treatment as well.

So yeah, that was a worry. So yeah, that was a worry. Now, even after being vaccinated, but less so. So in our last minute just tell us about your decision to get vaccinated, when you got vaccinated and how that went. I was extremely fortunate that I’m working in a hospital environment.
I work in an emergency room. And my hospital did an amazing job of rolling out the vaccine to staff as soon as possible. It was something I had been thinking about. As soon as we started hearing about a vaccine. And of course I talked it over with my medical oncologist before moving forward with the vaccine. But knowing the potential devastating effects of covid and seeing what it did, it really seemed like an easy choice and the right choice for me.

Christina Allen is a cancer survivor and Doctor Tara Sanft is an associate professor of medicine in medical oncology at the Yale School of Medicine. If you have questions, the address is canceranswers@yale.edu and past editions of the program are available in audio and written form at yalecancercenter.org. We hope you’ll join us next week to learn more about the fight against cancer. Here on Connecticut public radio.