Hospital Focuses Attention on next Phase of Breast Cancer Battle: Survival

By Tyler Smith

At institutions like University of Colorado Hospital, clinicians continue to score impressive successes in their battles with various forms of cancer. Increasingly, however, providers are recognizing that treatments with radiation, surgery, chemotherapy, and molecular therapies, even if they are successful, are often only the opening skirmishes in a long engagement with the long-term effects of the disease.

The clash extends beyond the physical. For example, surgeons at UCH are skilled at reconstructing breasts of women battling cancer. But the battle is also about helping women rebuild their lives, both physically and emotionally, as survivors.

October is Breast Cancer Awareness Month, billed as a time to raise awareness of the importance of early disease detection. But the support women need to lead productive, satisfying lives after breast cancer treatment hasn’t always kept pace with medical advances, said Tatyana Popkova, director of the cross-enterprise surgical program at UCH.

“We are very good at saving lives,” Popkova said, “but we need to do more to help women rehabilitate and give them a good quality of life.”

The question of how to move on after treatment is especially pressing for the quarter-million women age 40 or younger in the United States diagnosed with breast cancer, Popkova added.

“These are women with 30 to 40 years of life ahead of them,” she said. Nothing can return their lives fully to what they had been, Popkova said, but providers can help all survivors maintain their health with good nutrition, exercise, abstinence from drugs and alcohol, and regular primary care.

On to the next. That’s the aim of the Survivorship Clinic, which began in March in the Breast Center at UCH. The clinic opened in response to an initiative by the American College of Surgeons, which accredits the Breast Center, said Practice Manager Lisa Bellamy.

The standard, recently revised, asks institutions to implement “pilot survivorship plans” that cover 10 percent of eligible patients by Jan. 1, 2015. “Eligible patients” are defined as those who have completed active treatment (excluding long-term hormonal therapy) with the intent to cure. Each eligible patient is to receive a treatment summary and plan of care for the days ahead.

So far only the Breast Center and the GI/Surgical Oncology clinics have survivorship visits at UCH, but the aim eventually is to roll out the concept to the rest of the Cancer Center, Bellamy said.

In the Breast Clinic, patients who visit the Survivorship Clinic spend one hour with one of two nurse practitioners, Colleen Dougherty-Gray, MS, FNP, or Roberta Silveira, MS, FNP. They receive a detailed “Cancer Treatment Summary” that includes, among other things, their diagnosis, the care team members, the treatment and therapies they received, recommendations for follow-up care, and reasons to contact their providers, such as new lumps in the breast or persistent coughing. A second document lays out the follow-up guidelines, including imaging requirements.
Hard choices. The documents are heavy on clinical detail, but the visits also touch on psycho-social issues, Dougherty-Gray said.

“Breast cancer affects the patient at every level,” she said. “We often discuss the emotional aspects of patients returning to a normal life.”

That return can traverse many different paths and terrains. For example, with or without breast reconstruction, women face a variety of physical challenges, Dougherty-Gray said. These include changes in skin tone, loss of sleep, hot flashes, and night sweats. Physical issues, in turn, may spawn emotional trials, such as difficulties reconnecting with spouses or significant others.

With women who choose breast reconstruction, Dougherty-Gray said she turns her focus to helping them learn to self-examine the chest wall and axillaries for new lumps. Women with implants must learn to distinguish a truly suspicious area from a valve or the edge of the implant. Some women decide against reconstruction or implants, but struggle with wearing prostheses comfortably, especially for activities like swimming.

“A lot of the visit is simply listening and helping patients define the problems they are facing,” Dougherty-Gray said.

She also uses the visits to point women to additional resources. For example, cancer treatment may affect a woman’s ability to have children. Oncofertility specialists with the Advanced Reproductive Medicine program can help guide her decision. The Young Women’s Breast Cancer Translational Program, led by Virginia Borges, MD, is a resource for women with pregnancy-associated breast cancer. For women suffering through hot flashes, Dougherty-Gray has recommended acupuncture and homeopathic treatments. A recent addition is a clinical psychologist, Laura Melton, PhD, who is dedicated to the Cancer Center. That is an important piece of the care puzzle, Dougherty-Gray said.

Regaining what was lost. To be sure, clinical expertise is a prerequisite to superior overall care, and a surgical procedure like breast reconstruction can be an important component of healing. Women with breast cancer who have had single or double mastectomies have a variety of reconstructive options, said David Mathes, MD, chief of the Division of Plastic and Reconstructive Surgery at the University of Colorado School of Medicine.

“We can’t give a woman her breast back, but we can do a good job of reconstructing it so she won’t have to think about that and can worry about it less and less,” Mathes said. “That can help her move on from a tough diagnosis.”

The challenges of survivorship are apparent when Mathes discusses breast reconstruction. Many women choose to have implants, which often require two surgeries, one to insert a tissue expander to create room for the implant, and a second for the implant itself. However, implants carry a long list of complications, including infections, breast pain, and the risk of rupturing the outer shell.

Radiation also poses a reconstructive dilemma. It effectively reduces the risk of cancer returning to the breast and the surrounding area, but it also makes the skin less pliable and therefore difficult for the reconstructive surgeon to work with and shape, Mathes said.

Healing harvest. Of course, women may choose not to reconstruct the breast and opt instead for a prosthesis. For women who want reconstructive surgery, however, Mathes said there are a variety of procedures that involve harvesting a flap of skin, tissue, blood vessels, and sometimes muscle from another part of the body, moving it to the chest, transplanting it microsurgically, and forming a new breast.

In a DIEP (deep inferior epigastric perforator) flap procedure, for example, the surgeon cuts fat, skin, and blood vessels from the lower abdomen, while preserving the abdominal muscle. In the TRAM (transverse rectus abdominal muscle) flap procedure, the
The surgeon also removes a small amount of muscle. In both cases, the surgeon reconnects the veins and arteries of the flap to ensure a blood supply to the transplanted material, then reconstructs the breast.

Because they use the patient’s natural skin and tissue, flap procedures give surgeons the best chance of restoring the natural look of the breast, Mathes said. But he added there is no single, best answer for a woman choosing a procedure — or none at all. Women who have not had radiation have the broadest range of choices; women who don’t have enough abdominal muscle for a DIEP or a TRAM flap procedure might opt to harvest tissue from the inner thigh, the buttocks, or the back, Mathes said.

“We try to match women’s expectations to their options,” he said.

Mathes stressed that reconstructive surgery is “a process, not a procedure.” Patients may need more than one “revision” surgery. They may also take their reconstruction in stages, opting, for example, to wait a period of time before recreating the nipples with tattooing. Mathes said he counsels women to make those decisions when they feel comfortable to do so.

Whatever the type of procedure, the major goal of reconstruction is to restore a woman’s sense of “being more whole” and to allow those who choose to do so to function without a prosthesis, he said. He also encourages women to speak to others with experience before they make a decision.

“I can offer patients various types of surgeries, and I can explain the procedures and risks,” Mathes said. “But I haven’t undergone the procedures.”

The ultimate goal of survivorship is to put as much decision-making power as possible in the hands of the patient, Dougherty-Gray concluded.

“We want to start laying the groundwork for surviving the disease at the time of diagnosis,” she said, “and at every phase help patients define what their needs are by teaching them the things about their disease to be aware of.”

David Mathes, chief of CU’s Division of Plastic and Reconstructive Surgery, says breast reconstruction can help women regain a portion of their lives.

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