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Are Surgeons Still Doing Sentinel Node Biopsies In Older Women

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language, comorbidities, and insurance status were analyzed against type of breast surgery and reconstruction decision as endpoints. Also analyzed was whether or not the patient was offered breast conserving therapy (BCT), and their ultimate decision. RESULTS: 335 patients underwent total mastectomy (TM) and 194 underwent partial mastectomy (PM). Better imaging and clinical response to NAC preoperatively was associated with PM on univariate analysis ($p<0.001$, $p<0.005$), and having a genetic mutation identified preoperatively correlated to TM more often than PM ($p<0.005$). Surgeon recommendation of BCT was associated with more PM than TM on both uni- and multivariate analyses ($p<0.001$). No significance was found in final surgery type when analyzing race, primary language, age at diagnosis, county versus private hospital, or surgeon gender. Immediate reconstruction was more likely to be performed in the private hospital setting, at a younger age, and in patients with private insurance ($p<0.05$). CONCLUSION: The surgeon's recommendation for breast conserving surgery was a significant predictor of the final type of breast surgery, and not influenced by any disparity factor. Patients offered partial mastectomy tended to accept, across all groups. The decision for immediate reconstruction was influenced by disparity factors, but interestingly, no difference was found in type of final breast surgery between any disparity factor, translating to equal treatment across all groups.

Significant factors affecting final surgery

Covariate		Univariate			Multivariate		
	N	PM (%)*	TM (%)*	P value	OR	95% CI	P value
Total pts	529	36.7	63.3	-	-	-	-
Imaging response to NAC:	.	.	.				
None / progression	67	17.9	82.1				
Complete response	91	58.2	41.8	<0.001	-	-	-
Calcifications only	32	37.5	62.5				
Less than 50% reduction	93	44.1	55.9				
More than 50% reduction	122	43.4	56.6				
Clinical response to NAC:	.	.	.				
None	68	29.4	70.6	0.003	-	-	-
Complete	180	50.0	50.0				
Improvement	186	36.0	64.0				
Genetic mutation:	.	.	.				
No	162	37.7	62.3	0.004	-	-	-
Yes	58	17.2	82.8				
Recommended for BCT:	.	.	.		.	.	
No	202	5.4	94.6	<0.001	-	-	<0.001
Yes	263	64.6	35.4		0.024	(0.012,0.046)	
	N	No Recon (%)*	Immed. Recon. (%)*	P value	OR	95% CI	P value
Age at diagnosis	485	50+/-10**	45+/-10**	<0.001	0.943	(0.920,0.966)	<0.001
Insurance type:	.	.	.		.	.	
None	94	87.2	12.8		-	-	
Medicare/Medicaid	110	78.2	21.8	<0.001	2.235	(0.090,5.102)	0.001
Parkland Health plus	58	91.4	8.6		0.850	(0.269,2.683)	
Private	206	56.8	43.2		3.452	(1.647,7.231)	
Hospital:	.	.	.		.	.	
County hospital	211	88.6	11.4	<0.001	-	-	<0.001
University private hospital	274	60.9	39.1		2.889	(1.578,5.291)	

*Percentage of total N in each treatment category are reported in table. **Age reported as age range, not percentage.

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Are Surgeons Still Doing Sentinel Node Biopsies In Older Women?

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INTRODUCTION: SSO published guidelines suggesting that surgeons should not routinely perform sentinel lymph node (SLN) biopsies for patients (pts) ≥ 70 years of age (yo) with hormone receptor positive, her2 negative (HR+her2-) early stage invasive breast cancer (IBC). METHODS: We evaluated HR+her2- early stage IBC patients (pts) who were accrued to a multicenter trial between 2016-2018. Lymph node (LN) evaluation was left to the discretion of the treating surgeon. We sought to determine whether those ≥ 70 yo were treated differently in terms of LN staging than their younger counterparts, the results of the SLN biopsy, and its impact on adjuvant chemotherapy (ctx). RESULTS: 229 pts with IBC < 2 cm participated in this study; 76 (33.2%) were ≥ 70 yo. ER, PR and her2 status was known in 201 (87.8%). The proportion of pts who were HR+her2- was similar in the older vs. younger cohort (89.9% vs. 86.4%, respectively, p=0.653). Of those who were HR+her2-, the older cohort was no different from the younger in terrms of pt race, ethnicity, size and grade of the IBC, palpability, EIC and LVI. SLN biopsy was equally likely to be performed in the older and younger cohorts (91.9% vs. 97.4%, respectively, p=0.132), and final LN positivity was also similar for both groups (12.6% vs. 14.0%, respectively, p=0.812). Pts in the older group were less likely to receive ctx (5.9% vs. 19.4%, p=0.029), as were LN negative patients (9.9% vs. 47.6% for LN positive patients, p<0.001). On multivariate analysis, both of these factors were found to be independent predictors of receipt of ctx. While younger pts were five times as likely to receive ctx than their older counterparts (OR=5.295; 95% CI: 1.297-21.612, p=0.020) independent of LN status, those who were LN positive were ten times as likely to receive ctx than their LN negative counterparts (OR=10.772; 95% CI: 3.423-33.900, p<0.001) independent of age. Indeed, among pts ≥ 70 yo, LN positive patients were more likely to receive ctx than those who were LN negative (25.0% vs. 2.6%, p=0.071). CONCLUSION: Despite the "Choosing Wisely" guideline, over 90% of pts ≥ 70 yo with HR+her2- IBC underwent a SLN biopsy. SLN status influenced the receipt of adjuvant ctx in these pts.

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Patients Awaiting Mastectomy Report Increased Depression, Anxiety, and Decreased Quality of Life Compared to Patients Awaiting Lumpectomy for Treatment of Breast Cancer

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Introduction: There is a trend to increasing mastectomy (TM) for treatment of breast cancer despite studies demonstrating equivalent survival and better postoperative outcomes with lumpectomy (PM). There is a need to better understand the constellation of physical and mental health conditions patients face in the preoperative period. The objective of this research is to measure aspects of patient's preoperative mental health and identify differences in between patients scheduled for TM and PM. Methods: This study was based on a prospectively recruited cohort of consecutive patients scheduled for breast cancer surgery at our institution between April 2016 and July 2020. Preoperatively, participants completed a survey which included the Patient Health Questionnaire (PHQ-9) for depression, the General Anxiety Disorder-7 (GAD-7) for anxiety, the pain intensity (P), interference with enjoyment of life (E), and interference with general activity (G), known as the PEG, for pain and the EQ-5D(5L) for health status. Participants also reported their chronic health conditions. Scores were calculated for each instrument and compared for TM and PM. Results: The overall response rate among all eligible patients was 31% with 667 participants. The average age was 59 years. The most common comorbidities were hypertension (27%), arthritis (24%) and depression (13%.) Among participants, 477 were scheduled for PM (71.5%) and 190 were scheduled for TM (28.5%.) TM patients reported more severe symptoms of anxio-depressive disorders: with higher levels of depression (5.3 versus 4.2; $p < 0.01$) and anxiety (5.7 vs 3.9; $p < 0.01$.) There were no differences in pain. Participants scheduled for PM reported high health status compared to participants scheduled for TM (75.0 vs 70.7; $p < 0.01$.) Conclusion: Patients scheduled for TM reported more severe symptoms of depression and anxiety than those scheduled for PM. This information will be useful when counselling patients about surgical options. Preoperative referral to mental health providers may offer an opportunity to enhance perioperative care.