COVID 19 and breast surgery – silver linings?

Editor

The full impact of coronavirus disease 2019 (COVID-19) on breast cancer patients is unknown until studies such as the National B-Map-C (https://associationofbreastsurgery.org.uk/professionals/research/news-and-hot-topics/) are published.

Since the COVID-19 pandemic, there have been huge changes to most outpatient clinics[1]. World-wide there is a greater use of telephone consultations to break bad news such as giving a breast cancer diagnosis[2]. Providing virtual care may be the new way forward[3].

In the era of COVID-19 women with benign disease (typically include women with breast pain as an only symptom and with normal imaging below the age of 25) are no longer attending outpatients[4]. To reduce demands on clinics, going forwards this may become embedded in future management protocols.

In COVID-19, there have been significant changes in breast cancer surgery[4]. Alarmingly, initial reports suggest the mortality for COVID-19 patients undergoing general surgery to be as high as 20·5 per cent[5]. The Association of Breast Surgery has issued guidance that reconstructive surgery should be deferred or delayed[4] although we are aware these services are set to resume soon under the oversight of regional 'cancer hubs' limiting the collateral damage[6]. Elective surgical activity has reduced with operating rooms converted to makeshift intensive care units[7]. In UK hospitals most elective surgical work has been cancelled and surgical lists significantly reduced. In addition to theatre list reduction, theatre time per case has significantly increased due to additional personal protective equipment and a new 20-min period of ventilatory air-changes between patients. Rationing of services is offered to cancer patients requiring same day discharge. Patients requiring a mastectomy often require an overnight hospital stay. The changes required to facilitate day case mastectomy in our units have been achieved in days rather than the longer timespan originally anticipated. Additionally, there has been a reduction in postoperative drains (minimizing follow-up reviews).

Breast surgery training is likely to be compromized with uncertainty for trainee rotations including the National Training Interface Fellowships in advanced oncoplastic surgery[3]. These are highly competitive posts and further guidance is still awaited. In the UK, many breast surgical trainees have been redeployed to manage acute surgical admissions and COVID-19 patients. Formal training for breast surgical trainees in our region has ceased. Remote teaching platforms are developing and alternative methods of training such as e-learning or webinars may need to be adopted. Weekly multidisciplinary meetings are still being held but with a shift to remote working where possible[4].

Clearly, COVID-19 has changed the landscape in breast surgery. The full impact of COVID-19 on breast cancer patients is unknown and may only become evident over time. Breast teams are resilient in the event of a crisis. What has been achieved in weeks may have required many months to accomplish otherwise. Many adaptations may be used for the long-term benefit of patients. Specific guidelines should be updated continuously based on new evidence[8]. The 'silver linings' may occur through improved triaging of patients referred to breast clinics, utilization of telephone consultations and improved platforms of online training for trainees.

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