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ASO AUTHOR REFLECTIONS

ASO Author Reflections: Disparities in Oncologic Surgery: The Problem We All Live with

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PAST

The twentieth and twenty-first centuries brought significant technological and therapeutic advancements in the diagnosis and treatment of cancer. For breast cancer patients in developed countries, the implementation of population-based screening has resulted in earlier stages of diagnosis and lower mortality rates.[1] Moreover, the understanding of breast cancer as both a local and systemic disease has translated into de-escalation of surgical management in the breast and axilla, thus decreasing surgical morbidity.[2] Unfortunately, in the USA, historically marginalized and minoritized populations have not fully benefitted from these significant advancements in oncologic care. Specifically, the uninsured, Medicaid-insured, those with low socioeconomic status (SES), and Black women continue to present with advanced stages of breast cancer and consequently have higher mortality rates than their privately insured, high-SES, and White female counterparts.[3,4] Possible drivers of these disparities include, but are not limited to, differences in access to and receipt of high-quality surgical care.

PRESENT

Obeng-Gyasi et al.'s study defining populations of nonmetastatic triple-negative breast cancer patients at risk of rapid relapse highlights the implications of disparate surgical management on clinical outcomes.[5] In their study, rapid relapse was defined as disease-specific mortality within 24 months of diagnosis. Compared with patients who did not experience rapid relapse, those in the rapid relapse group were more likely to have surgery omitted based on a surgeon's recommendation. Furthermore, when they did undergo breast surgery, the rapid relapse cohort was less likely to undergo axillary staging. Notably, the population of patients at risk for rapid relapse, Black women, the uninsured, or Medicaid insured, are patients who have historically faced barriers to receiving surgical care. The results from this study emphasize the need for additional research to understand and define disease-related, patient, physician and institutional characteristics that could be contributing to disparities in surgical management among this subset of oncology patients.

FUTURE

Health disparities, healthcare disparities, and health equity have moved to the forefront of national dialogue only secondary to the COVID-19 pandemic. For surgical oncologists, this rise in public discourse and consciousness provides an opportunity for the field to reevaluate access to, and delivery of, guideline-concordant and high-quality oncologic surgical care. Studies such as the one by Obeng-Gyasi et al. suggest minoritized and marginalized populations, in addition to low-income patients, continue to face significant barriers in surgical management of their disease,

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resulting in poor clinical outcomes (e.g., mortality). To this end, future studies need to focus on optimizing the patient–surgical oncologist relationship in conjunction with developing strategies to define, identify, and intervene upon disparities in surgical management.

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