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PRS GLOBAL OPEN

VIEWPOINT

Breast Cancer Extirpation, Reconstruction, and COVID-19: Paradigm Shifting Management during a Global Pandemic

Armin Edalatpour, MD; Kylie M. Edinger, MD; Brian H. Gander, MD; Samuel O. Poore, MD, PhD

COVID-19 has changed societal norms and continues to impact our health care system and economy in ways that have never been documented before. The realm of plastic surgery is no exception to this threat and uncertainty. In addition to complete cessation of cosmetic and most elective surgeries, we have also noticed an interesting trend in patients undergoing breast cancer care at our own institution during the COVID-19 pandemic. Many patients previously scheduled for mastectomy with breast reconstruction were converted to breast conservation therapy (BCT) during the pandemic. At our institution during the months of August, September, and October of 2019, 112 (41%) patients underwent mastectomies, whereas 163 (59%) patients were elected to undergo BCT. During the same period, 93 patients had breast reconstruction surgery. In contrast, during the months of March, April, and May of 2020, when COVID-19 was at its peak, of the 123 breast cancer patients who underwent surgical intervention, the majority opted for BCT over mastectomy [90 patients (73%) versus 33 (27%) patients]. During the same period, only 13 patients had breast reconstruction.

In March of 2020, Centers for Medicare and Medicaid Services released recommendations to postpone elective and nonessential surgeries and procedures during the COVID-19 pandemic.[1] Additionally, the American College of Surgeons and the American Society of Breast Surgeons released guidelines regarding the care of breast cancer patients during the COVID-19 pandemic. Recommendations included opting for breast conservation wherever radiation oncology services were available and delaying breast reconstruction unless it was deemed medically necessary.[2] This led to a nation-wide decrease in breast reconstruction. Although this situation is unprecedented, some similarities can be seen in oncological care of breast cancer patients in rural settings.[3]

With limited access to plastic surgeons, BCT with radiation therapy is accepted as an appropriate treatment and locally established standard of care for early stage breast cancer in rural areas. As a result of this, fewer patients in the rural communities undergo mastectomy with breast reconstruction.[4] Despite evidence showing immense quality-of-life benefits of breast reconstruction after mastectomy, many continue to argue that there is not a direct positive impact on mortality and morbidity, and as such, these reconstructive surgeries are often categorized as elective and, therefore, nonurgent.[5] Perhaps in an attempt to alleviate potential bed crunches, and the need to preserve resources, there is an important role of enhanced recovery after surgery protocols, including the use of liposomal bupivacaine, and a shift to outpatient management in specific patient populations (eg, tissue expander patients).

Drastic societal changes are often observed during times of hardship, and COVID-19 has proved this, with the changes we have seen in society and the healthcare system as we continue to battle this pandemic. Although some of the changes are fleeting, others are evolving to become new established norms. With that in mind, is the future care of oncologic breast patients changing? And if so, where does the plastic surgeon fall within that care team?

Samuel O. Poore, MD, PhD
Division of Plastic Surgery
600 Highland Ave. CSC G5/347
Madison, WI 53792
E-mail: poore@surgery.wisc.edu

DISCLOSURE

The authors have no financial interest to declare in relation to the content of this article.

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From the Division of Plastic Surgery, University of Wisconsin School of Medicine and Public Health, Madison, Wis.

Received for publication November 6, 2020; accepted December 9, 2020.

Plast Reconstr Surg Glob Open 2021;9:e3396; doi: 10.1097/GOX.0000000000003396; Published online 26 January 2021.)