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Reply: Breast Surgery in the Time of Global Pandemic: Benefits of Same-Day Surgery for Breast Cancer Patients Undergoing Mastectomy with Immediate Reconstruction during COVID-19

Sir:

We sincerely appreciate the comments provided by Dr. Jean-Claude Schwartz regarding our publication.¹ The budding topic of same-day surgery for mastectomy has certainly gained immense traction given the pandemic and its impact on hospital resource allocation. We acknowledge that overall, our own experiences, previous research, and Dr. Schwartz’s study² uphold the consistent outcomes of reduced readmissions, reoperations, and postoperative complications following same-day surgery for mastectomy.

Our protocol involves a prospective, single-arm, multi-institutional study that primarily seeks to measure complications, pain, satisfaction, and cost subsequent to same-day surgery for mastectomy with reconstruction. (This trial is registered under the name “Same-Day Discharge after Nipple-sparing Mastectomy or Skin-sparing Mastectomy with Breast Reconstruction,” ClinicalTrials.gov identification no. NCT04596683, <https://clinicaltrials.gov/ct2/show/NCT04596683>.) Inclusion criteria consist of women with breast cancer electing mastectomy with immediate implant-based reconstruction who are amenable to same-day surgery. Exclusion criteria include active smoking and high-risk comorbidities (e.g., cardiac disease, diabetes, and so on). Distinct from Dr. Schwartz’s article, we opted for the validated BREAST-Q survey to collect data on satisfaction and the standardized American Pain Society survey to evaluate postoperative pain. We have enrolled approximately 40 patients treated by various providers within a single hospital system, albeit all operations have been performed within the hospital operating rooms and not in separate ambulatory surgery centers.

Ideally, randomization would have been the gold standard for reporting on a relationship between same-day surgery and improved outcomes. However, without mitigating difference in cost to the patient and influence on satisfaction for those unhappy with treatment allocation, we felt our chosen research design to be more appropriate as an initial study. We have

not encountered a study to date that has randomized patients into same-day surgery for mastectomy. Unless evidence demonstrating potential compromise to clinical equipoise is elucidated, this should be the aim for future studies.

While we believe the primary goal of our research is to demonstrate equal if not improved outcomes and satisfaction for women undergoing same-day surgery for mastectomy with reconstruction, a secondary critical component is cost. Dr. Schwartz comments on the financial benefits to same-day surgery, which is very applicable in the time of SARS-Cov-2. In his study, he emphasizes data demonstrating reduced infection rates to infer cost-effectiveness of same-day surgery for mastectomy.² While this is a notable assumption, it is not direct evidence. With access to billing information for cohorts that have been either discharged from same-day surgery or admitted following mastectomy, we are conducting a thorough cost analysis of the procedures. In addition, all procedures are performed in the same settings with similar staff and protocols, further reducing potential confounders to our results.

Similar to the evolution of reduced length of stay following the transition from radical to simple mastectomy,³ the recent advancements in anesthetic protocols and techniques for breast reconstruction serve as the catalyst for change in the standard timing of hospital-level treatment. We completely agree with Dr. Schwartz’s last comment, that admission following mastectomy should eventually be the exception, rather than the standard. Thorough research into the ideal characteristics of patients and resources required to appropriately educate and support same-day surgery for mastectomy is critical. Nonetheless, studies such as Dr. Schwartz’s² and ours¹ promote the transition to same-day surgery as a means of improved quality, satisfaction, and cost of reconstruction for breast cancer patients.

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DISCLOSURE

Dr. Tousimis receives honoraria for speaking faculty from Medtronic. Idanis M. Perez-Alvarez has no financial interests to declare.

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The COVID-19 Pandemic: Crisis Management for Plastic Surgeons

Sir:

We read with interest the November 2020 article by Hollier et al.¹ addressing the implications of crisis management on plastic surgeons during the current coronavirus disease of 2019 (COVID-19) pandemic. In their article, the authors define and describe how disaster response principles can be applied to plastic surgery practice throughout the COVID-19 pandemic. We commend the authors for providing this background on crisis management and discussing how these principles can be utilized by plastic surgeons to combat the COVID-19 crisis. We would like to propose additional areas where complementary crisis management strategies may be applied.

To reduce the burden on health care systems during the COVID-19 pandemic and future epidemics, many guidelines propose cancelling or delaying elective and nonemergent procedures. While this simple step is a vital part of crisis management, the cancellation of cases and in-person educational opportunities will have a significantly impact on resident education.² Plastic surgery education therefore requires its own crisis response and postcrisis recovery planning to ensure quality resident education. During the pandemic, teleconferencing can facilitate educational engagement through simulated patient case presentations, surgery livestreams, journal clubs, and didactic conferences.² However, digital solutions do not address the loss of operative experience. It may be prudent to expand the use of simulation technology as a means to teach and maintain operative skills, for which there are examples in ear, nose, and throat, general, vascular, and hand surgery.^{3,4} We also foresee the need for postcrisis planning to address resident education in the aftermath of the pandemic. The Accreditation Council for Graduate Medical Education has allowed programs to assess trainees' competence, rather than require a minimum number of logged cases. However, particularly for shorter training programs, such as fellowships, we anticipate a potential need to extend training or supervision to ensure surgical competency.

The private practice sector was tremendously impacted by COVID-19, as seen by the decrease in the number of elective aesthetic procedures performed in 2020.⁵ As part of crisis management, Hollier et al.

suggest temporarily reducing malpractice insurance, providing resources for small business loans, and encouraging businesses to reduce operational costs by maintaining only essential staff. While these measures may allow businesses to survive temporarily, they are not viable long-term solutions. Moving forward, plastic surgeons will need to implement safety mechanisms such as regular employee COVID-19 screening, preoperative COVID-19 screening for patients, and acquisition of sufficient personal protective equipment.⁵ Practices would be wise to transition to preoperative and postoperative visits using telehealth technologies, such as Zoom, WebEx, FaceTime, and MD-Live. It is also important for private practices to plan for prolonged postcrisis recovery. COVID-19 resulted in high unemployment rates and an economic downturn. Since most elective procedures are not covered by insurance, there will likely be fewer patients seeking aesthetic surgery in the coming years. Thus, practices must plan to scale down in light of decreased demand nationwide.

In their article, Hollier et al. effectively describe crisis management and outline a variety of ways these strategies can be applied by plastic surgeons during the COVID-19 pandemic. In this communication, we suggest the expansion of crisis management strategies to resident education and long-term financial planning for the private practice sector.

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DISCLOSURE

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

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