Funding for Yale Cancer Answers is provided by Smilow Cancer Hospital.

Welcome to Yale Cancer Answers with Doctor Anees Chagpar.

Yale Cancer Answers features the latest information on cancer care by welcoming oncologists and specialists who are on the forefront of the battle to fight cancer.

This week it’s a conversation about advanced techniques in breast surgery with Doctor Tristen Park.

Dr. Park is an assistant professor and Doctor Chagpar is a professor of surgical oncology at the Yale.
School of Medicine.

Tristen, maybe we can start off by you telling us a little bit more about yourself and what it is you do.

Sure. So I'm an assistant professor of surgical oncology specifically taking care of breast cancer patients and patients with breast disease. I teach and help mentor medical students and residents at the Yale School of Medicine as well as the Yale General Surgery program. We also have a wonderful breast cancer fellowship. So we also train fellows.

and I help in their education and
clinically I take care of locally advanced and early stage breast cancer patients as a surgeon and my other research interests include the use of immunotherapy and the treatment of triple negative breast cancers. And I’m also involved in some international work with collaborations with large cancer centers in the East Asia, namely South Korea. Great. So let’s dive into some of the work that you’ve been doing and particularly today we wanted to find out a little bit more about surgical management of breast cancer.
cancers as well as some of the more newer techniques that are being used. So maybe you could start off by painting a landscape of what surgery really looks like for breast cancer patients, when do they need surgery and what kind of surgery are we talking about when we think about surgery for breast cancers?

So anyone with early or locally advanced breast cancer needs surgery, that’s part and parcel of the multidisciplinary approach to treating breast cancer in 2023. So anyone that has breast disease or breast cancer that’s localized
to the breast or the lymph nodes
would need a surgery in conjunction
with local radiation therapy on some
sort of systemic therapy that may
be chemotherapy or endocrine therapy
and now immunotherapy as well,
something that targets the immune
system to help decrease the size
of the cancer if not make it go
away and prevent recurrences.
So that’s kind of thinking of it
as a three pronged approach.
The treatment of breast cancer and surgery
is definitely a very important part of it.
Yeah. And so when we think about
surgery for breast cancer,

I often think about it kind

of in two separate buckets.

So surgery for the breast cancer

itself within the breast and then

So maybe we could talk a little bit

about each of those two buckets.

So when a patient comes to you

and has say an early stage breast

and you’re thinking about

how are you going to remove this

from the breast itself,

what are the options that

you lay out for patients?

Well, a lot of it has to do with the
00:03:46.860 --> 00:03:49.508 subtype of cancer and the tumor
00:03:49.508 --> 00:03:53.170 to breast ratio for the patient.
00:03:56.122 --> 00:04:01.156 So an easy way to think about it is if it’s a
00:04:01.156 --> 00:04:03.858 smaller cancer that takes
00:04:03.858 --> 00:04:06.370 up less than 20% of the breast volume
00:04:09.410 --> 00:04:10.935 doing something called a partial
00:04:10.935 --> 00:04:12.735 mastectomy which is just removing the
00:04:12.735 --> 00:04:14.317 tumor with a rim of healthy normal
00:04:14.317 --> 00:04:18.020 tissue and not having to take the
00:04:18.020 --> 00:04:20.295 whole breast or a mastectomy is a
terrific option in this day and
00:04:20.295 --> 00:04:25.458 age that would be in conjunction with
00:04:25.458 --> 00:04:28.299 whole breast radiation therapy and
00:04:28.300 --> 00:04:32.017 If the tumor is much larger than
00:04:32.020 --> 00:04:34.001 than that and takes up a significant
portion of the breast, generally 30% or more, then removal via mastectomy and with some subsequent reconstruction most of the time would be the recommended course of action. And even for those patients that do have larger tumors, if they came to you and said, but Doctor Park, you know, I really want to save my breast. Are there tricks that you have up your sleeve that can help patients who want an option for breast conservation.
even if they have a larger tumor?

Well, definitely.

And now in this day and age, with all of our advancements in systemic therapy, we could do something called neoadjuvant systemic therapy to potentially shrink the tumor so that they could convert them from mastectomy to lumpectomy. So if it’s an estrogen receptor positive tumor, we could use estrogen blocking agents to shrink the tumor.

And then if it’s other subtypes, there’s other targeted therapies which
include drugs that target the HER2-Neu receptor or if it’s a breast subtype, breast tumor subtype that doesn’t express any receptors, immunotherapy, which targets the immune system in conjunction with chemotherapy, has had some very clinically meaningful shrinkages, if not complete responses, meaning the tumor shrinks almost completely, allowing for the tumor to shrink and therefore to fit that criteria to do breast conservation therapy. A lot of patients when they’re faced with a cancer diagnosis may understandably
be very anxious about that diagnosis. And may say things like, but you know, Doc, I’m not married to my breast and I just want it out. I don’t want to have to think I don’t want to worry about it anymore. What kind of conversation do you have with patients like that? Well, in the case where breast conservation is a very viable option for them and I feel like they’re speaking more out of anxiety, I go over the pros and cons of
a mastectomy including even with the mastectomy going absolutely perfectly there are long term kind of sequelae or ramifications that one would have to deal with which includes even if it goes absolutely perfectly, like the nerve supply to the breast skin is removed as part of the mastectomy. So the chest wall will be numb. Meaning that you won’t be able to feel people when they hug you or just even kind of practical things like you may accidentally burn yourself or if you leave a cold pack.
on that part of the body too long.

It’s like things like that to be concerned about in addition to,

you know,

smaller things like when you greet someone and hug them,

you won’t be able to feel that.

So I talk about that.

Even if everything went smoothly,

there’s always the risk of complications, which include infections

and wound complications,

chronic pain and therefore some further treatment and potentially

further operations.

So it’s one thing to take that as
a necessary cost if you have no other choice than to do a mastectomy because your tumors large and not responding to therapy and etcetera. But it’s another thing to have these two perfectly viable options and kind of subject yourself to something that may have more serious sequelae without you thinking through it very carefully. So I always bring that up. And sometimes that really gives patients pause and helps them make a decision not completely based on anxiety.
NOTE Confidence: 0.9394707
00:08:38.924 --> 00:08:41.044 have a genetic mutation and
NOTE Confidence: 0.9394707
00:08:41.044 --> 00:08:42.740 they’re thinking about people
NOTE Confidence: 0.9394707
00:08:42.816 --> 00:08:45.612 like Angelina Jolie who had both
NOTE Confidence: 0.9394707
00:08:45.612 --> 00:08:47.476 breasts removed and reconstructed?
NOTE Confidence: 0.9394707
00:08:47.480 --> 00:08:48.760 How do you advise them?
NOTE Confidence: 0.9394707
00:08:48.760 --> 00:08:51.304 I mean, is that an irrational
NOTE Confidence: 0.9394707
00:08:51.304 --> 00:08:53.000 decision that they’re making?
NOTE Confidence: 0.9394707
00:08:53.000 --> 00:08:54.760 How do you talk to them about that?
NOTE Confidence: 0.9292855
00:08:55.280 --> 00:08:58.240 Well, in the setting of a genetic mutation,
NOTE Confidence: 0.9292855
00:08:58.240 --> 00:09:02.460 since they do have a higher
NOTE Confidence: 0.9292855
00:09:02.460 --> 00:09:05.086 predisposition for 2nd cancers and
NOTE Confidence: 0.9292855
00:09:05.086 --> 00:09:07.716 other sporadic cancers,
NOTE Confidence: 0.9292855
00:09:07.720 --> 00:09:09.532 that’s kind of a different
NOTE Confidence: 0.9292855
00:09:09.532 --> 00:09:11.185 population than someone that
NOTE Confidence: 0.9292855
00:09:11.185 --> 00:09:13.397 just has an isolated breast cancer.
NOTE Confidence: 0.9292855
So that definitely is not unreasonable and that is a decent portion of the population that requests, you know, mastectomy for or even bilateral mastectomy for maximal risk reduction. But I kind of consider that as a separate group.

So for the patients who either opt for a mastectomy, either because they have cancer or because they may have a genetic predisposition or they may be at increased risk. Are there newer techniques that you’re now using that allow patients to have a better cosmetic
NOTE Confidence: 0.9396412
00:09:55.210 --> 00:09:57.674 result than what historically was
done in the past where patients were left with a flat chest wall?
NOTE Confidence: 0.9396412
00:10:00.415 --> 00:10:03.250 Well, now we have things,
I mean we definitely have reconstruction which is a partnership with a plastic surgeon.
NOTE Confidence: 0.9375404
00:10:06.730 --> 00:10:08.440 So the plastic surgeon would offer
some sort of reconstruction that might either may be in the form of implant or using their own natural
NOTE Confidence: 0.9375404
00:10:16.716 --> 00:10:19.262 tissue like from their belly that’s called the DIEP flat reconstruction.
NOTE Confidence: 0.9375404
00:10:23.180 --> 00:10:25.095 So that’s always definitely part of the conversation.
NOTE Confidence: 0.9375404
But from the purely the mastectomy standpoint, there's the use of something called ******** sparing mastectomy where the incision is hidden in the infra mammary fold, kind of like where you would think the underwire of your bra would be. So it's very hidden. So when you're sitting up, you can't see it and then all of the breast tissue and the surgery is done through that incision. It's basically like a hidden scar and the entire skin and **** shell is preserved. And when the reconstruction is completed,
00:11:02.480 --> 00:11:03.492 you know the outside
NOTE Confidence: 0.9375404
00:11:03.492 --> 00:11:04.757 portion of the body looks,
NOTE Confidence: 0.9375404
00:11:04.760 --> 00:11:06.230 you know pretty much the same as
NOTE Confidence: 0.9375404
00:11:06.230 --> 00:11:07.769 it did before because all of the
NOTE Confidence: 0.9375404
00:11:07.769 --> 00:11:09.717 skin and the ****** is intact and
NOTE Confidence: 0.9375404
00:11:09.717 --> 00:11:11.871 the the breast tissues removed and
NOTE Confidence: 0.9375404
00:11:11.871 --> 00:11:14.098 it has been replaced with either
NOTE Confidence: 0.9375404
00:11:14.098 --> 00:11:16.364 on the space has been replaced
NOTE Confidence: 0.9375404
00:11:16.364 --> 00:11:18.653 with either an implant or or
NOTE Confidence: 0.9375404
00:11:18.653 --> 00:11:20.118 the tissue from your abdomen.
NOTE Confidence: 0.9386749
00:11:21.520 --> 00:11:23.860 Are there risks associated with
NOTE Confidence: 0.9386749
00:11:23.860 --> 00:11:26.051 a ****** sparing mastectomy that
NOTE Confidence: 0.9386749
00:11:26.051 --> 00:11:27.719 you counsel patients about?
NOTE Confidence: 0.9386749
00:11:28.480 --> 00:11:31.948 Well, there’s definitely risk of practical
NOTE Confidence: 0.9386749
00:11:31.948 --> 00:11:34.605 risks that include like skin ****** necrosis,
NOTE Confidence: 0.9386749
meaning the blood supply to the ******
NOTE Confidence: 0.9386749

is compromised due to the to the surgery
NOTE Confidence: 0.9386749

and then over some time then the ******
NOTE Confidence: 0.9386749

may actually die and need to be removed,
NOTE Confidence: 0.9386749

which is definitely not a,
NOTE Confidence: 0.9386749

you know, a pleasant experience.
NOTE Confidence: 0.9386749

So we definitely counsel the patient
NOTE Confidence: 0.9386749

on the you know the potential of that
NOTE Confidence: 0.9386749

happening folks for folks that you know
NOTE Confidence: 0.9386749

are at the most risk of that would be
NOTE Confidence: 0.9386749

generally people with certain anatomy,
NOTE Confidence: 0.9386749

larger breast size, mortosis or droopiness,
NOTE Confidence: 0.9386749

smoking history, diabetes,
NOTE Confidence: 0.9386749

anything that could kind of compromise
NOTE Confidence: 0.9386749

the blood flow to to that area.
NOTE Confidence: 0.9386749

So generally we cut take that into
consideration when offering that type of procedure to patients as well. And if the patients are very enthusiastic about it despite having some, perhaps some of these risk factors, we definitely counsel them that you know they’re at a higher risk of necrosis and potentially additional surgery to have to remove it.

Are there other options for those kinds of patients? Well, there’s definitely options that include a skin spraying mastectomy with reconstruction.
In this day and age it could look extremely realistic with tattooing and a plastic surgeon reconstructs the breast. And you know, sometimes I can’t even tell the difference between a native area or complex on the left side versus a reconstructed one on the right side. So it’s quite realistic and advanced in this day and age. The other option if for instance the issue is too large of a breast size entosis is we could do something called a staged breast reconstruction.
00:13:17.350 --> 00:13:19.118 Spearing mastectomy where in partnership with a plastic surgeon, a breast reduction is done so that their anatomy is more amenable to spraying mastectomy. So usually decreasing the amount of tosis and decreasing the breast volume. And then after that’s all healed up then we do the actual spraying mastectomy. So in particularly in the case of gene mutation positive patients that don’t have an active cancer,
that could be a

nice kind of compromise like a nice stepwise way to get to the goal,

terrific. So we have to take a quick break for a medical minute.

Please stay tuned to learn more about advanced techniques and breast surgery with my guest Dr. Tristen Park.

Funding for Yale Cancer Answers comes from Smilow Cancer Hospital where 16 locations across the region provide patients with individualized, innovative, convenient, and comprehensive care.

Find a Smilow location near you at smilowcancerhospital.org.
There are over 16.9 million cancer survivors in the US and over 240,000 here in Connecticut. Completing treatment for cancer is a very exciting milestone, but cancer and its treatment can be a life changing experience. The return to normal activities and relationships may be difficult, and cancer survivors may face other longterm side effects of cancer, including heart problems, osteoporosis, fertility issues, and an increased risk of second cancers. Resources for cancer survivors are available.
available at federally designated comprehensive Cancer centers such as Yale Cancer Center and Smilow Cancer Hospital. To keep cancer survivors well and focused on healthy living, The Smilow Cancer Hospital Survivorship Clinic focuses on providing guidance and direction to empower survivors to take steps to maximize their health, quality of life, and longevity. More information is available at yalecancercenter.org.
00:15:27.490 --> 00:15:29.010 back to Yale Cancer Answers.

00:15:29.010 --> 00:15:30.610 This is Doctor Anees Chagpar,

00:15:30.610 --> 00:15:32.766 and I’m joined tonight by my guest,

00:15:32.770 --> 00:15:34.144 Doctor Tristen Park.

00:15:34.144 --> 00:15:35.980 We’re talking about advanced

00:15:35.980 --> 00:15:38.280 techniques in breast cancer surgery.

00:15:38.280 --> 00:15:39.880 And right before the break,

00:15:39.880 --> 00:15:41.880 we were talking about different

00:15:41.880 --> 00:15:43.080 techniques for mastectomy,

00:15:43.080 --> 00:15:45.168 so skin sparing,

00:15:45.168 --> 00:15:47.613 mastectomies, nipple sparing,

00:15:47.613 --> 00:15:49.719 mastectomies, etcetera.

00:15:49.720 --> 00:15:52.720 So before we leave the topic of mastectomies,

00:15:52.720 --> 00:15:54.638 Tristen, I was wondering if you could

00:15:54.640 --> 00:15:56.957 tell us a little bit more about
different techniques of reconstruction.

You had mentioned that, you know, in this day and age a lot of women can have reconstruction as opposed to being flat as was the case historically when people didn’t really have a choice. So what are the options for reconstruction and how do you, how do patients make a decision about what’s right for them? Sure. So I always tell my patients there are, definitely 2 viable options for reconstruction after after mastectomy. One is no reconstruction And then and then we discussed the use of
prosthesis and the pros and cons of not having needing additional surgery. And then, you know, then I say the other arm of that branch is doing some sort of reconstruction. And within reconstruction, there’s implant based reconstruction versus like tissue based reconstruction. So I counsel patients at implant based reconstruction is like the classical thought of the classical implant where an implant is used to, you know, reconstruct and take up the volume of the breast tissue that’s been removed. Generally it’s a 2 staged operation in...
00:17:19.912 --> 00:17:22.400 partnership with a plastic surgeon where
NOTE Confidence: 0.932896002222222
00:17:22.400 --> 00:17:24.974 they put something called expander in
NOTE Confidence: 0.932896002222222
00:17:24.974 --> 00:17:27.644 first which kind of is like a placeholder
NOTE Confidence: 0.932896002222222
00:17:27.644 --> 00:17:29.720 and then is the expanders is expanded
NOTE Confidence: 0.932896002222222
00:17:29.720 --> 00:17:32.443 over a period of a few months to the
NOTE Confidence: 0.932896002222222
00:17:32.443 --> 00:17:34.333 ideal size and then that’s switched
NOTE Confidence: 0.932896002222222
00:17:34.333 --> 00:17:36.619 out for the final permanent implant.
NOTE Confidence: 0.932896002222222
00:17:36.620 --> 00:17:39.338 So at that point you could get to the
NOTE Confidence: 0.932896002222222
00:17:39.340 --> 00:17:41.684 kind of goal breast size and then the
NOTE Confidence: 0.932896002222222
00:17:41.684 --> 00:17:43.714 final implant is placed with after the
NOTE Confidence: 0.932896002222222
00:17:43.714 --> 00:17:46.122 the rest of the tissues have have healed
NOTE Confidence: 0.932896002222222
00:17:46.122 --> 00:17:48.376 up well after the the index mastectomy.
NOTE Confidence: 0.932896002222222
00:17:48.380 --> 00:17:50.534 The other option is using something
NOTE Confidence: 0.932896002222222
00:17:50.534 --> 00:17:51.970 called tissue based reconstruction
NOTE Confidence: 0.932896002222222
00:17:52.023 --> 00:17:54.360 where in partnership with a plastic
NOTE Confidence: 0.932896002222222
00:17:54.360 --> 00:17:56.680 surgeon tissue from the abdomen or
other parts of the body could be used.

Although abdomen is the most common, that's called the DIEP flap reconstruction.

I basically in like layman's terms describe it as like a tummy tuck and the tissues then placed into the breast skin capsule to replace the volume.

So the pluses and minuses is that the implant based reconstruction is a little bit easier to do regarding time.

It adds you know maybe another hour to the surgery.

So that's the pluses of that.
00:18:31.010 --> 00:18:31.730 it’s not,
NOTE Confidence: 0.932896002222222
00:18:31.730 --> 00:18:33.641 you know some people think it doesn’t
NOTE Confidence: 0.932896002222222
00:18:33.641 --> 00:18:35.446 feel very natural and it does have
NOTE Confidence: 0.932896002222222
00:18:35.446 --> 00:18:36.844 to be replaced every 10 years.
NOTE Confidence: 0.932896002222222
00:18:36.850 --> 00:18:38.738 The tissue based reconstruction,
NOTE Confidence: 0.932896002222222
00:18:38.738 --> 00:18:41.570 it definitely feels more natural as
NOTE Confidence: 0.932896002222222
00:18:41.639 --> 00:18:43.928 it is you know your normal tissue
NOTE Confidence: 0.932896002222222
00:18:43.930 --> 00:18:46.310 and but it is a large operation
NOTE Confidence: 0.932896002222222
00:18:46.310 --> 00:18:48.809 that takes you know an additional,
NOTE Confidence: 0.932896002222222
00:18:48.810 --> 00:18:50.910 you know sometimes four to six hours
NOTE Confidence: 0.932896002222222
00:18:50.910 --> 00:18:53.230 where in a separate part of your
NOTE Confidence: 0.932896002222222
00:18:53.230 --> 00:18:55.866 body is being operated on and that
NOTE Confidence: 0.932896002222222
00:18:55.866 --> 00:18:58.006 technically doesn’t need an operation.
NOTE Confidence: 0.932896002222222
00:18:58.010 --> 00:19:00.775 So there’s always like complications
NOTE Confidence: 0.932896002222222
00:19:00.775 --> 00:19:02.775 and that are associated with that
NOTE Confidence: 0.932896002222222
00:19:02.775 --> 00:19:05.043 as well as kind of more intense
wound healing and just the recovery period because in addition to having your breasts operated on, you’re also having like your entire abdomen operated on as well. So that you know that kind of adds to the recovery period and the arduousness of the recovery. However, a lot of people like it because it feels very natural. It feels like it’s part of them, there’s no foreign body in there and it that this need for switching on an implant every so often.
10 years is then obsolete. Generally patients that are on the younger side, healthier and could tolerate a much longer operation and have this type of more complex reconstruction would be better candidates, although there are plenty of more elderly patients that could tolerate it just fine. As long as they’re in, they’re in good health. So I can imagine that you know, patients may have a number of questions.
are implants safe? There’s been.

Some horror stories in the past of implants rupturing,
of leakage, even of some cancers developing from implants.

So how do you counsel patients when they ask you are implants safe? Well,

implants are very safe.

Regarding the kind of concern about the the cancer formation,
it was a very rare type of lymphoma with a very specific type of textured implant that had been that particular type of implant has been removed from the market.

So you can’t get that anymore.
And even with that the incidence was extremely low. But that being said, it's off the market, you can’t physically obtain that type of implant even if you wanted to. So that has definitely been addressed quite thoroughly and patients have also been recalled, the ones that have gotten it to you know have them removed and replaced with a non textured implant. So there’s that and then there’s the more kind of common potential complications that that may include rupture or infection.
The risks of that are present, but it overall it’s like very well tolerated and you know if it does happen, you know it would have to result in a surgery to remove it and then replace it at a later time. But overall it’s considered a quite safe and well tolerated procedure.

Is everyone a candidate for the tummy tuck procedure? I can imagine that a lot of patients kind of get really excited about that, but some might not have enough belly tissue. So how do you kind of get around that and are there other contraindications?
to having a deep flap?

Yeah. So for the dip flap requires a kind of reconnecting these very small blood vessels together from the abdominal tissue to the chest. So if there’s any compromise to those little tiny blood vessels, like if you’re a smoker or have other vascular problems, you would not be a good candidate for that because that graft would not work. And then so that’s definitely a contraindication. You know, morbid obesity would be a contraindication.
So most of our plastic surgeons want the patients to be in a kind of more healthy BMI range to, you know, tolerate that type of surgery and the surgery itself is quite long. So it’s a good, you know, extra 6/6 plus hours of surgery. So to just be in good physical shape to tolerate that length of anesthesia and being in the operating room is necessary. If you’re too thin and do not have enough abdominal fat, abdominal tissue for this type of reconstruction.
You know some kind of like a hybrid approach. I've seen that spearheaded bioplastic surgeons where they combine both an implant with a deep flap or you know, tissue from a different area where you still have that kind of extra tissue coverage to make it feel natural. But you have the implant to, you know, give it, you know some more volume as well. So you know there’s there’s some tips and tricks that are plastic surgeons make use of in patients that have not enough tissue. So the other question that can come up is
after a mastectomy and and reconstruction. So now people look like they have a breast, although their breast tissue has been removed.

Do they still need a mammogram every year?

They do not need a mammogram every year because the definition of a mastectomy is removing all of the breast tissue. I usually quote like 9899% of the breast tissue is removed by the surgeon because we can’t remove every single last breast cell, but everything that’s grossly visible by the human eye of the surgeon is removed.

So with 90 you know 9899% of the
breast tissue being removed there.

There is no role for mammograms as there is no breast tissue left to detect.

So the main way that one would you know at that point you have maximally risk reduce the patient so that their future risk of developing any cancer is down to you know 1 to 2% maybe.

And if it does happen, it would kind of be discovered on the physical exam usually as some sort of finding on this usually under the skin somewhere and that's how it would manifest.

If that does happen,

you know,
NOTE Confidence: 0.93551993
00:24:53.630 --> 00:24:55.429 sometimes we ultrasound that to kind of
NOTE Confidence: 0.93551993
00:24:55.429 --> 00:24:57.388 confirm it and then you know biopsy it.
NOTE Confidence: 0.93551993
00:24:57.390 --> 00:24:59.693 But in general the role of screening
NOTE Confidence: 0.93551993
00:24:59.693 --> 00:25:01.469 mammograms is obsolete once all the,
NOTE Confidence: 0.93551993
00:25:01.470 --> 00:25:03.241 you know the most of the breast
NOTE Confidence: 0.93551993
00:25:03.241 --> 00:25:04.870 tissues removed after after mastectomy.
NOTE Confidence: 0.9411596
00:25:05.830 --> 00:25:08.710 So we’ve kind of talked about
NOTE Confidence: 0.9411596
00:25:08.710 --> 00:25:10.630 the techniques for mastectomy.
NOTE Confidence: 0.9411596
00:25:10.630 --> 00:25:12.190 You had mentioned before the
NOTE Confidence: 0.9411596
00:25:12.190 --> 00:25:13.750 break that the other option
NOTE Confidence: 0.9411596
00:25:13.811 --> 00:25:15.427 is breast conserving surgery,
NOTE Confidence: 0.9411596
00:25:15.430 --> 00:25:16.184 partial mastectomies.
NOTE Confidence: 0.9411596
00:25:16.184 --> 00:25:18.823 But one of the things that you
NOTE Confidence: 0.9411596
00:25:18.823 --> 00:25:21.159 had mentioned in terms of the
NOTE Confidence: 0.9411596
00:25:21.159 --> 00:25:22.984 mastectomy side was that for
NOTE Confidence: 0.9411596
patients who have larger breasts,
NOTE Confidence: 0.9411596
this can often be combined with a reduction.
NOTE Confidence: 0.9411596
So if people have larger breasts but
they want to preserve the breasts,
they want to have a partial mastectomy,
can they have a reduction as well?
Yes. That is definitely a great
tool in our pocket
for both treating the cancer
and sometimes having
very large breast size could be
a detriment to quality of life
like inability to exercise well,
like back pain, neck pain etcetera.
So in patients where breast
reduction could even improve their
their quality of life at baseline, it’s definitely like a wonderful option for patients. So in that setting usually it’s done in partnership with a plastic surgeon. The breast tumor is removed. The lymph nodes are tested and then concomitantly the plastic surgeon then with the leftover breast tissue does the breast reduction on both sides and then you’re left with a smaller breast size on both sides and the you know your breast cancer is removed and the lymph nodes are staged.
And that’s patients generally really appreciate that because it not only are you treating their breast cancer but their quality of life is definitely better due to decrease pain and improve mobility and ability to be more active. So then the other question that might come up is, that that might come up is, you know it’s really great that patients can get a reduction, they can get a lift potentially they can get maybe even a tummy tuck if they have a mastectomy with a deep flap.
gee, that all sounds very much like cosmetic surgery. Will my insurance cover this? So that that’s definitely a question that I get a lot. And as long as you have a cancer diagnosis and this is done in part, part and parcel with the removal of the tumor, it will be covered by insurance. And actually in the late 90s, the US government mandated that all breast reconstruction associated with breast cancer must be covered by all insurances. So that’s definitely like a
A great thing about, you know, the system that we have in place in this country. Yeah, including doing the symmetry operation on the other side, right. If they have a reduction, correct. Most of the time, the symmetry operations can be done concurrently, but sometimes patients opt to wait until their complete cancer treatment is finished on the cancer side. And then after everything’s healed up and radiation is finished, which may alter the size of the breast bearing the cancer.
Then we know what we're dealing with in the symmetry procedure could kind of replicate exactly the end product of the other side. And that's called a symmetrizing procedure and that's definitely covered as well. Doctor Tristan Park is an assistant professor of surgical oncology at the Yale School of Medicine. If you have questions, the address is Cancer Answers at Yale dot Edu, and past editions of the program are available in audio and written form at yalecancercenter.org.
We hope you’ll join us next week to learn more about the fight against cancer here on Connecticut Public Radio. Funding for Yale Cancer Answers is provided by Smilow Cancer Hospital.