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00:00:00.076 --> 00:00:21.769 Announcer Funding for Yale Cancer Answers is provided by Smilow Cancer Hospital. Welcome to Yale Cancer Answers with the director of the Yale Cancer Center, Doctor Eric Winer. Yale Cancer Answers features conversations with oncologists and specialists who are on the forefront of the battle to fight cancer. Here's Doctor Winer.

00:00:21.846 --> 00:01:01.153 Eric Winer Tonight, we're talking with Doctor Mehra Goshen, who is the executive vice chair in the Department of Surgery. He's also the deputy chief medical officer for surgical services in Smilow Cancer Hospital, and a professor of surgery at Yale School of Medicine. Maybe more importantly, he's a cancer surgeon, a breast cancer surgeon who has done multiple clinical trials and other types of investigation for many years and is both nationally and internationally recognized for his work.

00:01:01.230 --> 00:01:04.384 Eric Winer It's really a pleasure having you on tonight, Mehra.

00:01:04.576 --> 00:01:06.000 Mehra Golshan Thanks for having me.

00:01:06.153 --> 00:01:46.115 Eric Winer Let's start off talking about breast cancer surgery, where there's been so much change over the years. And and in particular, I think the breast cancer surgery community has led the way in reducing the morbidity and toxicities of surgery in a series of stepwise studies that have shown us that, in general, less is often more for many of our patients, not necessarily every single patient.

00:01:46.153 --> 00:01:58.346 Eric Winer So maybe we could just reflect back and you could talk a little bit about first what breast cancer surgery was like before either you or I were practicing.

00:01:58.461 --> 00:02:38.269 Mehra Golshan It's a it's a great question. And we still get this a lot from our patients who come and see us in clinic. And when they talk about a new breast cancer diagnosis. Still, there are many patients who think that bigger or more extensive surgery is actually better. And that's really what was the case, as you said, like in the 1950s and beforehand, where mastectomy or radical mastectomy, the removal of the entire breast, the skin, sometimes the muscle and all the lymph nodes were really the only treatment that was offered surgically.

00:02:38.269 --> 00:03:06.115 Mehra Golshan And it was really through the brilliant work of of a couple of surgeons, one, the late doctor Bernard Fisher and the, the other doctor and Berto Veronesi in Italy, where they decided to look at and compare less extensive surgery, the the lumpectomy or the partial mastectomy where you just removed the tumor and maybe a little rim of normal tissue and follow it with radiation.

00:03:06.192 --> 00:03:28.307 Mehra Golshan Comparing that to mastectomy and giving the woman the equivalent or the same outcome in terms of survival,

which has really been practice changing. And at least in the United States, you know, two thirds of women will go down that route of a less extensive surgery when appropriate.

00:03:28.384 --> 00:03:31.653 Eric Winer Are there people who still need bigger surgeries?

00:03:31.730 --> 00:03:56.615 Mehra Golshan There are. First of all, it's still it's a choice. And I think it's something that we do have to offer and go over the pros and cons of of women who want to choose a mastectomy or a more extensive surgery. Yet there are also women who absolutely should have that for. And those number of criteria are decreasing over time.

00:03:56.692 --> 00:04:37.153 Mehra Golshan But there are many women, not many. There are some women who still should end up having a mastectomy. And I would say, for example, if a woman goes down the route of lumpectomy and they have to come back multiple times for recreation, sometimes we can't get that margin clear after multiple attempts, that person may be best served with a mastectomy, a cancer that's come back after lumpectomy and radiation, especially if it hasn't been a long interval between the surgery, radiation and the cancer coming back probably would be best served with a mastectomy as opposed to another lumpectomy.

00:04:37.153 --> 00:04:44.807 Mehra Golshan But those criteria, the number of situations where it's an absolute indication, has decreased over time.

00:04:44.807 --> 00:05:14.423 Eric Winer And oftentimes when you need to perform a mastectomy or actually in patients who have a very good prognosis because it's what's called DCIs or ductal carcinoma in situ, which, you know, is is technically cancer. But many of us think of as almost pre cancer. But that that's prevalent throughout the breast and you can't clear it. I mean that's that is the case is not.

00:05:14.500 --> 00:05:40.423 Mehra Golshan Yeah. So often with this DCIs it's discontinuous growth. So there's like little pockets and islands of of this pre cancer cancer and the breast. And sometimes it doesn't show up really great on imaging. And we try to do a lumpectomy. And they come back with margins that are positive and not clear and then end up offering them a mastectomy.

00:05:40.423 --> 00:06:01.846 Mehra Golshan Or they present just upfront with a large area of often they present with calcifications in the breast. And this is a place where, at least to date, drug therapy hasn't been necessarily a great option to try to decrease that area of abnormality. And we offer them a mastectomy.

00:06:01.846 --> 00:06:39.269 Eric Winer And maybe we could talk for a few minutes about what goes along with with breast surgery, which is surgery to the XL or to the armpit, where there have also been really remarkable changes. And, you know, when I first was a breast cancer doctor, and for about ten years after that, there were more than ten years, the standard approach was if

a woman had an invasive breast cancer of almost any size, she had a full lymph node dissection, which was not the easiest thing.

00:06:39.269 --> 00:06:48.307 Eric Winer And in many ways, maybe not psychologically, but physically is a much harder operation than than either a lumpectomy or a mastectomy.

00:06:48.307 --> 00:07:22.230 Mehra Golshan I think before the late 1990s, early 2000, the standard of care was this surgery, called an lymph node dissection, where we took the majority of the lymph nodes from underneath a woman's arm, or a man who had breast cancers arm. And there was a lot of morbidity associated with that lymphedema or arm swelling like a ring or a watch feeling tight or their arm swelling after surgery was something that occurred 20 plus percent of the time.

00:07:22.307 --> 00:08:00.769 Mehra Golshan And over time, because of a lot of the advances in surgery, we've moved away from that more extensive operation under the arm. That actually lymph node dissection, I wouldn't say is a thing of the past, but it is not commonly performed now. And in fact, with a lot of our trainees, there's we have to find them and make sure that they get experience in doing that surgery, because there are cases where that more extensive surgery under the arm is necessary, and because it's not as frequent, they're not getting a lot of experience in that, which is not necessarily a bad problem to have.

00:08:00.807 --> 00:08:30.692 Mehra Golshan And I think the reason behind that was with the advent of what's called the sentinel lymph node biopsy. Again, several pioneering surgeons were able to either use a die or a nuclear tracer that travels from the breast to the lymph nodes under the arm. And we're able to test one or 2 or 3 lymph nodes. And if there's no cancer, in many cases, almost all cases not do any further surgery.

00:08:30.692 --> 00:08:51.307 Mehra Golshan And even if there is a little bit of cancer in 1 or 2 lymph nodes, potentially not do any further surgery because of the great treatment that's come around, both from the drug therapy or the medical oncology standpoint, which you provide in our radiation oncologists who often play a role as well.

00:08:51.384 --> 00:09:24.615 Eric Winer It is it is really remarkable how this has changed. And, you know, there were people 30 and 40 years ago who used to have terrible arm swelling after lymph node dissections, particularly lymph node dissections that were sometimes accompanied by radiation. And that's something we just don't see any more. So you hear a lot about people choosing to have bilateral mastectomies the minute they have breast cancer in one breast.

00:09:24.615 --> 00:09:55.000 Eric Winer And it's a it's been a trend for, for years that where there's been more and more of these of these bilateral mastectomies being performed, usually with reconstruction, oftentimes in big cities, what's going on there and what's what's what's driving that? Because I think many of us have thought that it doesn't make a lot of sense from the standpoint

of our available data.

00:09:55.076 --> 00:10:23.538 Mehra Golshan Yeah. So outside of those that have a hereditary predisposition, like the Angelina Jolie's or the Christina Applegate of the world, the removal of both breasts is not necessary in all cases. Yet it's a choice that women have insurance in the United States, at least as of still today, largely covers removal of one or both breasts and reconstruction of one or both breasts.

00:10:23.576 --> 00:10:39.269 Mehra Golshan If a woman has breast cancer, maybe about a decade and a half ago. You know, some people call this the Angelina Jolie effect. They, when she was diagnosed with breast cancer and chose to have bilateral mastectomies.

00:10:39.346 --> 00:10:45.230 Eric Winer But again, she had a gene mutation which put her a super high risk of a cancer in the other breast.

00:10:45.269 --> 00:11:08.307 Mehra Golshan Correct. And then again, in her case, that made sense. But once a a patient who may not have extensive medical knowledge sees on TV that someone like that shows it, then they're going to say, well, if she did, maybe I should. And again, it's it's not necessary in most of the cases, but we've done a lot of advances, both from the surgical techniques.

00:11:08.307 --> 00:11:36.269 Mehra Golshan So the removal of the breast where in the past reconstruction may not have been offered. Now we offer reconstruction. The reconstruction has improved dramatically, whether it's implant based or using your own bodies tissue. The mastectomy techniques have also improved quite a bit, where we can remove all the breast tissue and leave the skin, including the nipple, behind. In some cases where the the shell or the envelope remains the same.

00:11:36.269 --> 00:12:05.038 Mehra Golshan And I think because the of those improvements, both on the breast surgery side and the reconstruction side there, there has been a push towards more women choosing that route. Yet you do have to go over all the pros and cons in those cases, even if we can make it look really nice after surgery, the nerve endings are cut and they don't have very good sensation.

00:12:05.076 --> 00:12:30.576 Mehra Golshan They may get a little bit of their sensation back, but it'll never have the native sensation they did beforehand. Some reconstructions don't last forever, so implants often need to be exchanged. And even if you can use your own bodies tissue, there's often need for kind of filling in some of the gaps that haven't been fully reconstructed at the time of the original surgery.

00:12:30.692 --> 00:12:58.076 Mehra Golshan I think one other big push in this area has been because our imaging has gotten so much better, is that we're often detecting little areas of abnormality, and those areas of abnormality have always existed. But if a patient hears that there's like 2 or 3 spots, they may say, well, instead of going down the radical lumpectomy, let me remove 1 or 2

breasts or both my breasts and I, because I don't want to ever go through this again.

00:12:58.076 --> 00:13:03.807 Mehra Golshan So it takes a lot of time to talk about all the pluses and minuses before they make that decision.

00:13:03.846 --> 00:13:32.115 Eric Winer And of course, the other sort of minus or it's very much not a plus, is that for the patient who does not have a hereditary predisposition or a super strong family history and has a breast cancer on one side, there isn't any evidence that removing the other breast, it will allow her to live a day longer. So it ends up being very much a choice about quality of life.

00:13:32.115 --> 00:13:38.461 Eric Winer And I think sometimes people think that this is the answer to longevity, and it simply isn't.

00:13:38.461 --> 00:13:48.884 Mehra Golshan Absolutely. Removal of one or both breasts will not keep a woman alive longer than a lumpectomy with usually with radiation in most cases.

00:13:49.115 --> 00:14:00.653 Eric Winer So we're going to need to take a brief break. We'll be back in a minute and we will continue with our guest, Doctor Mehra Golshan. We'll be right back.

00:14:00.730 --> 00:14:29.576 Announcer Funding for Yale Cancer Answers comes from Smilow Cancer Hospital, where artificial intelligence works together with the latest imaging technology to help diagnose cancers at earlier stages and treat them more effectively. Learn more at SmilowCancerHospital.org. The American Cancer Society estimates that over 200,000 cases of melanoma will be diagnosed in the United States this year, with over a thousand patients in Connecticut alone.

00:14:29.576 --> 00:15:06.692 Announcer While melanoma accounts for only about 1% of skin cancer cases. It causes the most skin cancer deaths, but when detected early, it is easily treated and highly curable. Clinical trials are currently underway at federally designated comprehensive cancer centers, such as Yale Cancer Center and Smilow Cancer Hospital, to test innovative new treatments for melanoma. The goal of the Specialized Programs of Research Excellence in Skin Cancer Grant is to better understand the biology of skin cancer, with a focus on discovering targets that will lead to improved diagnosis and treatment.

00:15:06.730 --> 00:15:14.076 Announcer More information is available at YaleCancerCenter.org. You're listening to Connecticut Public Radio.

00:15:14.115 --> 00:15:44.461 Eric Winer Hello again. We're back for the second half of Yale. Cancer Answers. Again, this is Eric Winer. I'm a medical oncologist, and I'm joined tonight by Doctor Mehra Golsham, who is a breast surgeon and leader in breast cancer surgery around the world. So I thought we

could pick up talking a little bit more about something you mentioned, which is reconstruction and the improvements in reconstruction.

00:15:44.576 --> 00:16:16.692 Eric Winer Reconstruction used to be something that many women didn't choose to have, largely because it wasn't so great. And I think that at least 30 or or so years ago, there was also a sense that people who chose reconstruction were were somehow doing it because they were vain, a sort of a crazy idea, given the fact that people should be entitled to choose to have reconstruction without any judgments.

00:16:16.692 --> 00:16:32.730 Eric Winer And I think we're there now. In fact, we offer all people of all ages the chance to have reconstruction. Talk to us a little bit about the conversations you have with patients around reconstruction, since it seems that almost everyone chooses it these days.

00:16:32.807 --> 00:17:00.807 Mehra Golshan Yeah. So with a lot of the improvements with reconstruction has been because of our plastic surgery and reconstruction. Colleagues, for example, here at Yale will offer really the full gamut of options it can go from. None of it's necessarily simple, but the least complex would be an implant based reconstruction, where they can use either saline or silicone to recreate the breast mound.

00:17:00.807 --> 00:17:26.076 Mehra Golshan And then from the surgical standpoint, I could remove the breast tissue and again, in some cases remove all the breast tissue, but leave that full shell or envelope, which includes sometimes the nipple and Ariel behind. And over time, the reconstructive surgeons have also mastered a lot of techniques where if an implant is not the right option for the patient potentially using.

00:17:26.153 --> 00:17:58.230 Mehra Golshan In the past it was the skin, fat, and muscle from the abdomen or back, and now they can take just the skin and fat from the abdomen and other parts of the body and recreate the breast or the chest at the same time as the surgery that I'm performing. It's really improved both in terms of technique, the amount of time in the operating room, the recovery associated with the surgery, and the cosmetic outcomes.

00:17:58.230 --> 00:18:45.346 Mehra Golshan We have really talented microvascular breast reconstructive surgeons that look at the patient and talk to the surgeon, the medical oncologist, and if the radiation oncologist is involved, to get a better sense of the type of treatment the patient's going to have either before or after surgery. And we really partnered again to make sure that one, we can offer the reconstruction options of one or both breasts when appropriate, but also at the same time, there could be cases where there is a lot of extensive treatment required, or they have a very advanced cancer where reconstruction may either not be the best idea upfront, or it would be best to go down a more or a less

00:18:45.346 --> 00:18:54.576 Mehra Golshan invasive form of reconstruction, for example, by putting an implant or an expander, which is basically a partially

inflated implant at the same time.

00:18:54.615 --> 00:19:11.692 Eric Winer And how much harder are these procedures that involve autologous tissue, where tissue from the patient herself is moved from one part of her body to another? And does that depend on where the tissue is coming from?

00:19:11.692 --> 00:19:38.153 Mehra Golshan It does, because what it does is take blood supply from, for example, if they take it from the abdomen, they take the skin and the fat from the abdomen, and then they so it to very small blood vessels that course under the sternum or the chest bone. And it does require a team that is very both competent from the surgical standpoint.

00:19:38.230 --> 00:20:08.500 Mehra Golshan But it's often two reconstructive surgeons working together at the same time, one that works on kind of harvesting or getting the tissue ready from the abdomen, the other that prepares the site for where it ends up being connected. I would for sure if you're going to pursue one of those reconstruction options, go to a center like ours that has a lot of experience with microvascular reconstruction.

00:20:08.615 --> 00:20:25.884 Mehra Golshan The nice thing is when they take the skin and fat now and they can leave the muscle behind. Some of the problems with hernia development in the abdomen and bulging or weakness of the abdominal muscles has gone away, or has been diminished quite a bit with these improvements.

00:20:25.884 --> 00:20:39.576 Eric Winer It is remarkable how much all of this has changed. To what extent do you interact with medical oncologist and radiation oncologist? And is is that something that has changed over the years?

00:20:39.615 --> 00:21:24.000 Mehra Golshan Kind of date myself a little bit and maybe a little bit of of you. So you helped recruit me to my first job, which was back in Boston in 2002. And then again, we reconnected in 2021 when you joined Yale. And I joined in 2020, one of the first things that I learned, and I think the reason I'm trying to date both of us is that at that first recruitment dinner, it was you and your wife and doctor who was my chief at the time, and a surgeon and his wife that joined us in in Newton at Aquitaine, BC, a lovely bistro.

00:21:24.000 --> 00:21:49.346 Mehra Golshan And the reason why I think that's important is that you took it upon yourself to make sure that as a new surgeon coming out of training, that you're connected both with a medical oncologist with a lot of experience that was used. So my clinic for, I think, 15 of the 18 years was on Tuesday with you, but also with some of your more junior colleagues who had just finished training, like myself.

00:21:49.346 --> 00:22:15.307 Mehra Golshan And I think the importance is that we were we sit in clinic together. We often saw the patients consecutively. Either I saw them first you after or vice versa, and then we would chat informally

in the in the hallway, but then go back with one plan and make sure that we're all on the same page. We also brought radiation oncology to the table.

00:22:15.384 --> 00:22:53.115 Mehra Golshan Not all cases of breast cancer need radiation, but sometimes that decision making on whether radiation is going to be necessary, or the patient making a decision on whether to do a lumpectomy with radiation versus a mastectomy, hearing about that at the same time often is makes the difference. So I think it's absolutely critical. It continues here to in my time at Yale, I'm in clinic on Mondays, and it's always with a partner in medical oncology and radiation.

00:22:53.153 --> 00:23:17.500 Mehra Golshan Now, there are a few times where getting three, 4 or 5 appointments ends up being overwhelming, and we certainly don't want to make make sure that's not the case. But most patients want to hear everything up front as much as possible and to really see and feel the team. And I think that's something that you helped create a long time ago in Boston.

00:23:17.500 --> 00:23:23.230 Mehra Golshan And this certainly continues and is on a higher scale here at Yale.

00:23:23.307 --> 00:23:53.538 Eric Winer And of course, what's what's changed as well is the number of patients who receive medical therapy treatments like chemotherapy or immunotherapy or anti Her2 therapy upfront. And, you know, at this point for for patients who have what's called stage two and stage three. So cancer that is either a little larger in the breast or involves the lymph nodes.

00:23:53.615 --> 00:24:23.076 Eric Winer And who have her to positive or what's also called triple negative breast cancer. All of those patients receive initial medical therapy. And of course, the benefits there are that we not only help prevent a recurrence of the cancer elsewhere in a woman's body, but we can shrink the tumor and that can convert somebody who might otherwise need a mastectomy to having a lumpectomy.

00:24:23.269 --> 00:24:26.423 Eric Winer I mean, you've been involved in several studies like that.

00:24:26.461 --> 00:24:54.653 Mehra Golshan You know, one of the best things about the work that you do in your medical oncology colleagues is that there are now, in those hurt to positive or triple negative, those more aggressive breast cancers, such so much better therapies that have improved the results so much that maybe half the time and sometimes even more, I will call the patient after surgery and tell them that there was actually no more tumor that was viable, or it was all killed by the drug therapy.

00:24:54.653 --> 00:25:10.692 Mehra Golshan And that's often the best phone call. It's always the best phone call to give the patient was that the drug therapy destroyed the tumor. And that often gives a much better long term prognosis for the patient as well.

00:25:10.769 --> 00:25:39.884 Eric Winer Tell me a little bit about the relation-

ships you have with patients. You know, even though there are times when the medical oncologist sees the patient first, most of the time you're the first breast cancer doctor to walk in the room. You're there, you know, helping someone put together a treatment plan and sort out, you know, how they're going to get through this, you know, how is that?

00:25:40.000 --> 00:26:01.423 Mehra Golshan And I think if you asked me this maybe 20, 25 years ago, I used to walk in with a very kind of I had a almost like a book answer. It was, you know, I done it a lot. I was a very I am and, but was a much busier clinical surgeon at the time. And, you know, I thought I really kind of knew what a patient wanted to hear.

00:26:01.423 --> 00:26:31.153 Mehra Golshan They wanted to hear lumpectomy, radiation, statistics, recurrence, you know, like how much, you know, how many of these do I do? Like, what are the areas that I published. And and as you know, about seven years ago I actually was diagnosed with cancer myself, not breast cancer. And I think when you have the tables turn and you go from being a physician to a cancer patient yourself, it completely changed kind of my approach to, to the patient.

00:26:31.192 --> 00:26:57.153 Mehra Golshan I mean, I still offer the same surgeries and options, but I really walk into the room wanting to know what they want to hear. There are those that want to hear every statistic. One of the papers that I published, you know, how many do I do? Why should I come here, you know, versus going to another center? And there are others who just want to know that they're going to be okay, and you're going to take care of them.

00:26:57.230 --> 00:27:19.807 Mehra Golshan I don't think there's one answer for every patient. When I walked in and my surgeon and oncologist wanted to start giving me those numbers and statistics, I actually didn't want to hear that. I just wanted to know that I was going to be okay. Later. Yes, I did ask some of those questions, but at the beginning, that's not what I wanted to hear.

00:27:19.807 --> 00:27:39.500 Mehra Golshan So I don't think there's really one glove that fits everyone here, and it's not the way I wanted to learn to be a to be a better doctor by going through some of the things that our patients do. But certainly it's something that I've learned and changed over the course of the last several years.

00:27:39.576 --> 00:28:07.423 Eric Winer It's a remarkable thing that, you know, you have essentially taken care of breast cancer patients your entire life. That's that's all that you've done. And yet I have no doubt whatsoever that still walking into that room is sort of a new experience every time, and a new and fascinating experience with every patient. Well, it's been a pleasure having you on the show.

00:28:07.423 --> 00:28:38.461 Eric Winer We're going to have to wrap up. I have been joined tonight by my colleague, Doctor Mehra Golshan, who is the

executive vice chair in the Department of Surgery, a breast cancer surgeon and researcher, and a professor of surgery at Yale School of Medicine. To our audience, thank you very much for being with us. I'm going to sign off now and we'll be talking again next week.

00:28:38.500 --> 00:28:57.576 Announcer If you have questions,the address is CancerAnswers@Yale.Edu and past editions of the program are available in audio and written form at YaleCancerCenter.org. We hope you'll join us next time to learn more about the fight against cancer funding for Yale Cancer answers is provided by Smilow Cancer Hospital.