THE BIG 5 IN BREAST CANCER CARE
EX AFRICA SEMPER ALIQUID NOVI

Prof Carol Benn
AWARENESS: I AM LION ...HEAR ME ROAR
ESTIMATED BREAST CANCER MORTALITY WORLDWIDE IN 2008

GLOBOCAN 2008, International Agency for Research on Cancer

Age-standardised mortality rates per 100,000
**INCIDENCE OF BREAST CANCER IN SOUTH AFRICA**

- The National Cancer registry in South Africa last released statistics in 2012
- Currently a committee has been set up to try and ensure accurate recording of the statistics
- The registry is pathology based and not population based ......so true incidence is unknown
AWARENESS

- Ignorance as to disease presentation and fear results in 70% of women presenting with locally advanced breast cancer
- There is no screening program in South Africa
- Some of the medical insurances fund mammography, should the woman decide to request a mammogram?

Education is inexpensive awareness
BACKGROUND......FROM BARA TO HJH

Request at Bara

- Multi-disciplinary unit
- Breast as a recognized specialty
- Turned down....and moved to HJH
- No clinic only old OPD

HJH

- National health invested in unit build
- Old casualty convert
- Unique unit..
Education needs to be culture specific.......with Community navigators.
CREATING AWARENESS, ACCESS AND SUPPORT

HOW ARE WE DOING?
- 11 years of reaching out to women
- 245,375 women seen and educated
- 885 clinics visited
- 1070 breast cancers diagnosed because of Breast Health Foundation counsellors
- 1070 women diagnosed early because of BHF
Breast Care Centre of Excellence

Contact: 011 4805779
HOSTILE HOSPITAL ENVIRONMENTS.....ARE LIKE THE LEOPARD....
HEALTH CARE ROLE MODEL
CURRENTLY 2 HEALTH CARE MODELS ARE AVAILABLE IN SOUTH AFRICA

A private model based on medical insurance funding, which allows access to private health care facilities.

Public services: for uninsured patients, usually those of lower socio-economic background, who access state run facilities.

- Problems .... for many patients many medical aids offer minimum to little support.....not an aid.....an insurance raid
Access to services is a further frustration, no clear medical pathways as to where to go, and when services are available.

Most times outlying government based clinics and hospitals see patients with breast related problems but do not have facilities to diagnose nor treat.

Referral systems are fragmented and complex....and transport costs to patients result in poor follow-up compliance.

Patients pay for each visit in government.
10% of patients are new cancers and further treated at HJH
List determined by consultant on and not patient choice

METHODS OF REFERRAL TO HJH BREAST CLINIC

Private Hospitals

Other

Media and Events

Governmen t Clinics and outreach

Clinics and Partner hospital Outreach

Social Media and associated NGO's refer to HJH Breast clinic

Event 8

HJH Breast Clinic

Administration responsible for cost (government mean assessment test)

Tuesday New Patient Clinics

Thursday New Patient and follow up Clinic

10% of patients are new cancers and further treated at HJH
List determined by consultant on and not patient choice

Calling into the BCCE helpline gives the offer to contact HJH. Doctors at Milpark refer to the nearest Public hospital to provide breast specific services (HJH Breast Clinic)
HELEN JOSEPH BREAST UNIT

- The clinic manages 500-700 patients each month in two weekly specialist clinics.
- The Centre has kept separate hospital records since 2008.
- Seen and followed-up more than 12,000 patients in that time.
- Based on the most recent statistics, approximately 3000 new patients are seen per year. 60% of these patients will have a consultation for free, or for less than $4.
COSMOPOLITAN UNIT

- 65% black patients; 18% white, small bias Asian 9% (7%)
- This breakdown reflects Johannesburg

- 61% stage 3 and 4
- 28% under age 45
- 8% under 35
- 12% over 75
HJH AND NBC

- The 2 units see on average 25-30 new breast cancer patients per week
- 10 and 15 being diagnosed in the government based unit situated at the Helen Joseph Hospital - The majority of the patients present as locally-advanced disease and are referred immediately for primary chemotherapy.
- Patients from many private units access HJH.....the problems:
  - Often after private radiology and biopsies R140000
  - After “emergency breast cancer surgery”
3868 new patients seen in 2012

344 patients with new malignant diagnosis

- Invasive Ductal Carcinoma; 292
- Invasive Lobular Carcinoma; 12
- Other; 5
- DCIS; 13
- Sarcoma; 5
- Lymphoma; 7
Percent of New Cases by Age Group: Breast Cancer

Breast cancer rates are highest in people aged 55–64 years.

Median Age At Diagnosis

61
All HJBCC
55
Black pts
52
Routine staging examinations should include physical examination, including liver enzymes, alk. phos., ca, menopausal status and bone density is not a routine.

- Once off prior to treatment start
- Then only if symptomatic
- Mammography and ultrasound is yearly post diagnosis (not 6 monthly)

Metastatic work-up is not a Ca 153....only to measure metastatic response to treatment.

Variable definitions of what tests to do....but we over test; service and need more holistic approach to post treatment survivorship.
Breast Centres 'Without Walls’

- The many clinicians involved in breast care including medical, surgical, and radiation oncologists, maintain separate practices in different locations.
- Although women do not receive their care in a single location or facility, a nurse coordinator typically schedules the visits.
I am Buffalo, I have a mean and hungry look

Breast cancer should not be seen when big and ugly but spotted from afar when hiding
PATIENT CARE IN SOUTH AFRICA

- Multi-disciplinary units that fit all the recommended criteria are not the norm
- Access to health care let alone specialized breast units differs in urban and rural communities
- A few like-minded physicians who are prepared to work together,
- A small dynamic group of patients must create media and patient advocacy around the value of multi-disciplinary units
AN ONCOLOGY MULTIDISCIPLINARY MEETING

Each unit should have written documentation of:

- local treatment guidelines
- which international guidelines are followed
- which cases should be discussed that may fall outside of guidelines or require specific non-guideline based treatment choices and why
Breast Care Centre of Excellence

- Breast Surgeons
- Plastic Surgeons
- Medical Oncologists
- Radiation Oncologists
- Breast Radiologists
- Pathologists
- Psychiatrists
- Psychologist
- Geneticist
- Lymphoedema therapist
- Patient navigators
- Complementary team
- Research; Audit; and Data capture and Documentation
MDT virtual

- Newly Diagnosed
- Business
- Follow up
- Survivorship
- Academic
- Can be virtual....
Breast Care Centre of Excellence

“When your breast center achieves accreditation by the National Accreditation Program for Breast Centers (NAPBC) you can be assured that it is held to the highest standards of care for patients with diseases of the breast.”

www.facs.org

Dr. A. Grubnik
FC Plast Surg (SA), MMed (Wits)
MONEY MAY NOT BUY BETTER CARE

- Conversely the private hospitals provide access to any women who have medical insurance, with most surgeons in the private hospitals all too eager to diagnose and treat patients in non multi-disciplinary units.

- With emergency surgery...and patients ignorant of...downfalls of emergency cancer surgery.
Primary Oncology Care

- Buy in......but then convince around surgery
SURGICAL EXPERTISE

- Most patients in outlying areas are offered mastectomies, with a subset of women being offered breast-conserving surgery without onco-reconstructive techniques being used.

- Central units however, offer comprehensive breast cancer surgical managements with a comprehensive use of reconstructive options, good documented research, presentations and follow-up.

- The vast majority of women in the central units opt for immediate reconstruction.
FROM STATE OF THE ART
The next frontier
This may decrease cost in the long run
SSM and immediate prosthetic Recons
NIPPLE SPARING MASTECTOMIES
Breast conservation and reconstruction, gold standard....as long as access to radiation is possible.
Autologous reconstruction: LD

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Autologous reconstruction: LD

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Chasing the nirvana of the perfect breast reconstruction results in conflict between surgical oncology principles and aesthetically pleasing better functioning reconstructed breasts.
Goldilocks

Appearance after bi-lateral mastectomy
Background: Goldilocks


Contents lists available at SciVerse ScienceDirect
International Journal of Surgery
journal homepage: www.theijs.com

Original research

The Goldilocks mastectomy

Heather Richardson*, Grace Ma

Piedmont Hospital, Atlanta, GA, USA

ABSTRACT

Objective: To reconstruct a breast mound from cutaneous mastectomy flap tissue alone, obviating the need for additional flap or implant techniques.

Summary background data: With growing numbers of obese and elderly women facing breast cancer, options outside of simple mastectomy without reconstruction and formal breast reconstruction using complex autologous flap harvesting techniques or artificial implants need to be explored.

Methods: Patients who declined traditional methods of breast reconstruction were offered standard skin sparing mastectomy with closure utilizing a standard Wise pattern. A completely autologous breast reconstruction was performed using only the tissue that was formally excised.
For the subset of breast cancer patients with large or ptotic breasts who have chosen mastectomy without reconstruction, we feel there are advantages to having an additional choice in the Goldilocks mastectomy.
Goldilocks

Dr. A. Grubnik
FC Plast Surg (SA), MMed (Wits)
Autologous reconstruction: Goldilocks

Advantages:

➢ Bilateral total autologous reconstruction
➢ No donor site morbidity
➢ May avoid radiation
➢ Radiation resistant
➢ Ideal in patients with large ptotic breasts
➢ May be augmented with regional flaps

Disadvantages:

➢ Limited volume dependent on initial breast size
➢ Contour irregularities
➢ Nipple congestion/ necrosis
Procedure

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Goldilocks

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Goldilocks

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Locally advanced central tumours, which have had a good response to primary chemotherapy, are not contraindications for central breast excisions and reconstruction.
The funded patients in South Africa have access to a variety of oncology drugs including Herceptin.

Certain medical insurances offer limited access to these drugs with hefty co-payments.
PRIMARY CHEMO: RULES

- Place a marker (titanium) role for magseed in our setting
- Upfront decisions about
  1. Tumour size
  2. Multicentricity
  3. Extent of lymph node involvement
     (today this is assessed radiologically)
- Document prior to starting chemotherapy who will need radiation post surgery
- Triple negative poor responders may be offered platinum based second line upfront
PERSONALIZED ONCOLOGY

NO LONGER ONE SIZE FITS ALL

- Chemotherapy today is more individualised and less recipe as more combinations of drugs become available
- TAC for triple neg
- TCH for her 2 neo-adjuvant
- Weekly Taxol for luminal A (LABC)
Radiation Therapy Available
IORT Systems of kV versus MV Devices

Carl Zeiss INTRABEAM and Xoft Axxent eBx vs IntraOp Medical Mobetron
RADIATION THERAPY DISCUSSIONS

- Criteria for intra-operative radiation should be assessed according to (ASTRO 2017 guidelines)
- Need for radiation due to axillary nodal disease (1 or more involved)
- Whether the unit follows the Z11 protocol and AMAROS trial outcomes
- Documentation of radiation need prior to starting primary chemotherapy
When breast cancer and HIV are found together...

- Thought to be more aggressive, bilateral with unusual histology and at a young age
  - Little evidence to support this
  - May be a product of the age rather than disease
  - Epidemiology may indicate some protective effect

- Difficult to stage because of confounding disease
  - HIV lymphadenopathy can mimic involved nodes
    - Unilaterally and bilaterally
    - Important to have histological confirmation
    - SLNB very useful
  - Multiple disease processes at presentation
    - NHL and TB
    - Kaposi and breast cancer
    - Breast cancer and lymphoma
THE EFFECT OF ADVANCED BREAST CANCER ON QUALITY OF LIFE

- The physical issues of pain, odour and loss of function must be carefully considered when deciding on treating or withholding treatment in these women.
There is most definitely a place for surgery in patients with advanced breast cancer, the question is when.
Radiation Access and Availability

- A large number of state patients (most of whom require radiation due to initial advanced presentation of the disease), do not have easy access to either transport or funding
- Shortage of radiation units in the government sectors often requires patients to take the duration of radiation time as leave from work
- Compliance is variable
- Elective breast conserving surgery decisions are often “not” chosen based on radiation access
I AM ELEPHANT, I NEVER FORGET

living for a long time with a diagnosis ...should be our goal
.No “I” in team…. But of course there is a “me”…….the future …….SURVIVORSHIP

Oncology care physician

Caring for the family
OUTCOME PREDICTORS

- Cultural Sensitivities
- Disease profile: (young age of presentation, HIV, and high incidence of triple negative breast cancers)
- Socio-economic (time off work, family dynamics)
- Need for navigation through different hospital systems
I am Rhino, please save me

Service is critical
Burden of disease in LMI countries
Shortage of clinicians
Insufficient Radiation machines
High percentage of LABC
Lack of reconstruction in LABC
Access to care
Shades of grey, in terms of poverty, education, and late disease presentation are further darkened by inadequate medical care.
NO BARRIERS TO EXCELLENT BREAST CARE

Multidisciplinary centres in Johannesburg, Cape Town, Stellenbosch, Durban
CREATING AWARENESS, ACCESS AND SUPPORT
CREATING AWARENESS, ACCESS AND SUPPORT
WHAT CAN YOU DO TO SECURE THE FUTURE FOR WOMEN’S HEALTH?

South Africa’s BIG FIVE of Women’s Health

- We are working together to achieve comprehensive women’s health
  - Access to breast, cervical and HIV screening in one clinic at Helen Joseph Hospital [with social work support for abuse]
- Model to be rolled out dependant on NGO and DoH assistance
- Help needed with:
  - Navigators and counsellors acting as umbrella for patients
  - Infrastructure and administration- database work
  - Community education of comprehensive care
NICE

- Africa Renaissance
- Many reconstructive options
- Health education
- Technology aiding clinicians
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Any questions?
THE RAINBOW NATION: A SPECTRUM OF CANCER PRESENTATION, AND A KALEIDOSCOPE
LIKE A RAINBOW…

A few driven clinicians across the country, who although are as unique as each colour

- strive daily towards the pot of gold of true excellent patient care
- ensuring an integrated, education orientated, multidisciplinary approach; with cost effective service delivery and high quality patient care