WHAT THE PAST IS TELLING US ABOUT THE FUTURE

Alberto Costa, MD
Milan, Italy – Lugano, Switzerland

•

LE COMMEDIE DI
CARLO GOLDONI
La locandiera

"He's angry about getting old."

WHAT THE PAST IS TELLING US

- Too many things for a 30 minute lecture, unless we dedicate 1 min to each year of the great time I had between 1973 (the Milan I trial) and 2003 (the view on the Lugano lake).
- Still I would have to ignore the last 10!
- Let's choose 9 messages, in 3 triplets.

1) Breast Cancer is not one disease, but many

- We always knew that despite the fact that we were trying our best with every single patient, some of them would not manage to survive the disease.

- Since we could not predict who was going to survive we felt obliged to give the maximum tolerable treatment to everybody.

1) BCa IS NOT ONE DISEASE BUT MANY

- Things started to become clearer with the discovery of hormone receptors, then proliferation index, grading, vascular invasion, and Her2 test.

- Our knowledge might even further improve with gene profiling tests (if we will have the money to pay for them).

0,5 CM	3,5 CM
TUBULAR	LOBULAR
G1	G3
SENTINEL NODE NEG	7/20 METASTATIC LYMPH NODES
NO VASCULAR INVASION	VASCULAR INVASION
ER/PGR: 100%	ER/PGR:0
KI67: 5%	KI67: 60%
HER 2 NEG	HER 2 +++

1) BCa IS NOT ONE DISEASE BUT MANY

- Patients with BCa are different in Vienna, in Houston, in Cairo and in Bangalore.

- Their BCa cells maybe the same but their disease can vary dramatically from slow growing, hormone dependent, postmenopausal non-aggressive cancers to advanced, inflammatory, bilateral tumours in young women

2) ONE SIZE CANNOT FIT ALL

- Consistency requires that if we aim at personalised treatments, as we do, we should also aim at personalised early detection and risk reducing programmes.

- The past tells us that a mammography every 2 years was a great idea and the impact of screening programmes is certainly underestimated.

2) ONE SIZE CANNOT FIT ALL

- 60 million European women are involved in MRx screening programmes.
- 12 millions are screened every year
- But now we need more individual risk assessment, more personalised detection programmes, more Mrx density evaluation, some sound chemo-preventative intervention and/or lifestyle changes

2) ONE SIZE CANNOT FIT ALL

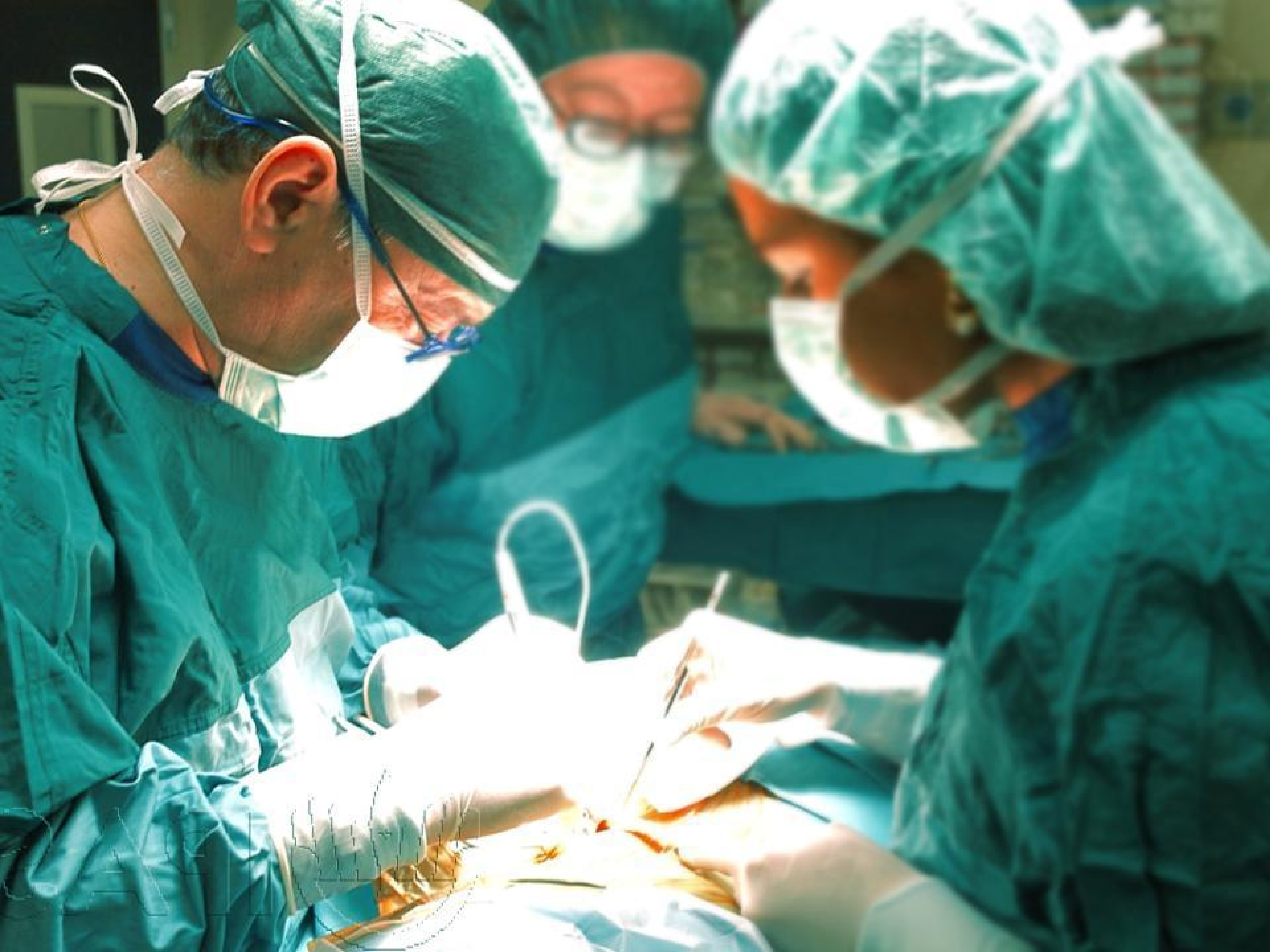
- Breast cancer management is leading personalised oncology

- TNM may soon become the past: the tumour size/breast size ratio is more important that the T diameter, the invasive vs invasive +DCIS settings are too different to be put together in the same T

3) NO SHORTCUTS

- The past tells us that there are no easy solutions (who remembers thermography?) nor final solutions (who remembers high dose chemo with bone marrow transplantation?)

- Look at MRI: great potentials, excellent performance in very specific settings, but very dangerous in wrong indications



4) BCa MANAGEMENT IS NOT ONLY BCa SURGERY

- Surgery was the only treatment for BCa for a long time and we all believed that the future of each patient (more or less) was in the skilled hands of the surgeon.
- Surgeons sometimes struggle to work in teams, but don’t shoot them - you will still need them for a while!

5) THE MORE YOU CUT THE MORE YOU CURE?

- Wise breast surgeons know that this is not true. They have pioneered conservative surgery, sentinel node biopsy, nipple sparing mastectomy.
  – Can we be even more conservative?

- The confusing use of the word “radical”:
  – To eradicate (excise the roots) <u>or</u> to get rid of the problem? (who remembers Dr Urban in New York?)

6) BUT WHEN YOU CUT, DO IT WELL!

- BCa surgery is not that easy:
  - It requires biological knowledge, attention to detail, taste, sense of proportion and of symmetry, passion for the woman body image

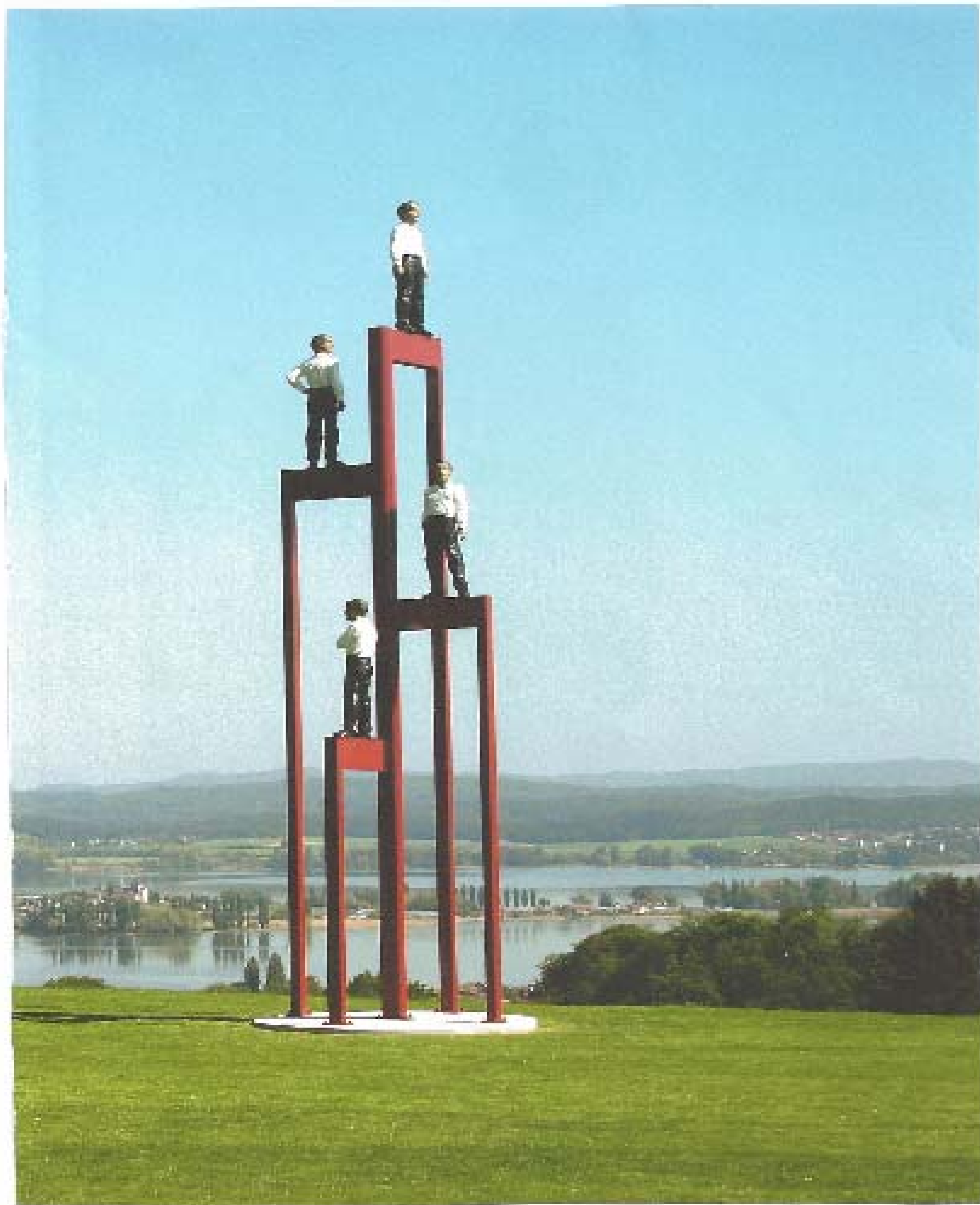
- Nothing is more frustrating for a surgeon than having to re-operate a patient for unclear margins to find out afterward that there was no residual disease.

7) NO PROGRESS WITHOUT RESEARCH

- The past tells us to be very careful in introducing new techniques or drugs or procedures before they are validated by a proper trial with a reasonable level of evidence.
- Even P values can be misleading. They can last for years (internal mammary node dissection in inner quadrants tumours) and then disappear...

8) BE INNOVATIVE:WORK IN MULTIDISCLIPLINARY TEAMS...

- No more individual breast cancer doctors but high quality certified breast units
- No breast units without a breast nurse
- Better still have a dedicated psychologist and a genetist.
- Even better if you can help with dietary advice, complementary medicine, physical exercise, and a self help group...



9) (and last): LISTEN TO YOUR PATIENT!

- The past tells us that it's often more difficult to listen to patients than to perform surgery, precribe chemotherapy or deliver radiation therapy

- But a well informed and trusting patient has more chance to benefit from your treatment and care

INVEST IN COMMUNICATION

- Find time to talk and explain
- Ask the patient do they want to be accompanied by a signficant other when you speak to her
- Make sure to have a nurse with you when you break bad news

OUR LANGUAGE
IS OFTEN STRANGE,
SOMETIMES BIZARRE…

Exact size

Proliferation

Grading

Sentinel node

BREAST CANCER PATHOLOGY REPORT: FROM ONE LINE TO ONE PAGE

Her 2-neg

Hormone receptors

Vascular invasion

INVASIVE CARCINOMA…

YOUR NODES ARE POSITIVE …

BE CONSISTENT, EMPATIC, EXPLICATIVE, OPTIMISTIC, PAY ATTENTION TO DETAIL (age, geographic origin, socioeconomics)

ALWAYS DO YOUR BEST TO MAKE YOUR PATIENT FEEL IN CONTROL…

INVICTA