

## Resource for Management Options of Breast Cancer During COVID-19

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**SSO supports the need for treatment decisions to be made on a case-by-case basis. The surgeon's knowledge and understanding of the biology of each cancer, alternative treatment options, and the institution's policies at the time the patient will be scheduled for surgery all need to be taken into consideration.**

**The information below is based on the opinions of individuals who are experts within the field of breast cancer and are members of the Society's Breast Disease Site Work Group.**

1. Atypia, prophylactic/risk reducing surgery and benign breast disease
  - a. Consults and any resultant surgeries can be deferred for at least 3 months unless patient is experiencing abscess/infection that has failed conservative/medical management/ultrasound guided percutaneous drainage.
  - b. Delayed or second stage reconstruction should be deferred for at least 3 months.
2. DCIS – All core biopsies demonstrating DCIS should be tested for hormone receptor status
  - a. ER+ DCIS can be treated with endocrine therapy (Tamoxifen versus aromatase inhibitor at the discretion of medical oncology) for 3-5 months. Reassessment of patients should be done via telehealth every 8-12 weeks to screen for progression (i.e. new mass or bloody nipple discharge).
  - b. ER- DCIS can likely also be delayed without therapy if low volume disease and low clinical/radiographic suspicion for invasive disease. Reassessment of patients should be done via telehealth every 4 weeks to screen for progression (new mass or bloody nipple discharge). These patients should be high priority for operation when deemed safe by the individual health system/hospital.
  - c. Large volume ER- DCIS/High grade DCIS/palpable DCIS can be delayed with close follow up at the discretion of the multidisciplinary tumor board. Reassessment of patients should be done via telehealth every 4 weeks to screen for progression (new mass or bloody nipple discharge). These patients should be very high priority for operation when deemed safe by the individual health system/hospital.
  - d. DCIS with microinvasion should have receptor testing performed on microinvasive component (if possible) and treated as per invasive cancer guidelines if ER+. If the invasive component is ER-, can be treated by ER- DCIS guidelines as neoadjuvant chemotherapy would NOT be recommended. These patients should be high priority for operation when deemed safe by the individual health system/hospital.

3. ER+ invasive breast cancer, Stage I-II
  - a. Genomic testing – if felt that genomic testing will determine endocrine versus chemotherapy, this should be performed on the core biopsy.
  - b. If amenable to endocrine therapy, patient can be treated with neoadjuvant endocrine therapy for at least 3-5 months. Reassessment of patients should be done via telehealth every 4 weeks to screen for progression.
    - i. If patient is postmenopausal, can treat with aromatase inhibitors versus Tamoxifen at the discretion of medical oncology
    - ii. If patient is premenopausal, should consider ovarian suppression and either Tamoxifen or aromatase inhibitor
  - c. If chemotherapy is indicated, can start chemotherapy (see below)
  - d. For advanced stages (III-IV), per multidisciplinary discussion, consider primary endocrine or chemotherapy
4. Triple negative/HER2+ invasive breast cancer
  - a. Patients with T2N0-3M0 or T0-4N1-3M0 disease should begin neoadjuvant chemotherapy
  - b. Patients with T1N0M0 disease should be considered high priority for surgery. Can consider neoadjuvant chemotherapy in large T1 tumors or as per multidisciplinary tumor board recommendations.
5. Post-neoadjuvant chemotherapy
  - a. ER+ invasive breast cancer
    - i. If the patient had a partial/complete clinical response, can consider converting to endocrine therapy in order to delay surgery versus surgery in 4-8 weeks. Reassessment of patients should be done via telehealth every 2-4 weeks to screen for progression.
    - ii. If the patient is also HER2+, can consider converting to endocrine therapy in addition to anti-HER2 therapy in order to delay surgery versus surgery in 4-8 weeks. Reassessment of patients should be done via telehealth every 4 weeks to screen for progression.
  - b. Triple negative/HER2+ invasive breast cancer
    - i. Delay within a 4-8 week post-chemotherapy window, depending on response as long as possible. These patients should be high priority for operation when deemed safe by the individual health system/hospital.
6. Unusual Cases/surgical emergencies/special considerations
  - a. Patients with progressive disease on systemic therapy, angiosarcoma and malignant phyllodes tumors should be considered for urgent surgery and should not be delayed.
  - b. All surgeries amenable to same day discharge and/or 23 observation should be performed as such. ERAS protocols should remain in place to ensure timely discharge.
  - c. All postoperative visits should be considered for telemedicine unless the patient has an acute issue or requires suture or drain removal.
  - d. Second opinion consultations where the patient is actively being treated should be done by telemedicine.
  - e. Surveillance visits should be done via telemedicine or delayed 1-3 months should they be coupled with screening mammogram.