Regional Breast Disease Working Group: Another Dimension of Breast Care

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Weekly prospective treatment conferences for breast cancer are the mainstay of most comprehensive breast centers. It is at this conference that the multidisciplinary experience of patients seeing multiple physicians becomes interdisciplinary in nature - with the multiple physicians discussing the same patients and reaching a consensus recommendation. These prospective conferences typically include a single hospital medical staff. This article describes the efforts in northwest Houston where physicians from several competitive hospitals have developed a bi-monthly, regional breast cancer conference with the purpose of discussing problems encountered with complex cases and solutions attempted. The article discusses the due diligence process required to establish a regional conference and the inevitable OncoPolitics that arose among the physicians. The program has evolved into a mature meeting characterized by open and honest dialogue, collaborative discussion, and a sincere commitment to the conference.
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The hospital began its quest for better breast diagnostics and treatment in the early 1990s. Initially, a lead surgeon with a keen interest in breast disease and a similarly talented breast radiologist began honing their respective skills, and the plans for a breast center were formulated. This nascent breast team encouraged the hospital to buy one of the first stereotactic core biopsy units in Houston. A few surgeons and the breast radiologist attended the required training sessions before the purchase and implementation of the stereotactic needle core program. The first breast needle core biopsy was in February 1993.

The breast center has progressed considerably since that date. In November of 1995, a threesome team composed of a surgeon, the breast radiologist, and this pathologist attended a watershed Laszlo Tabar Interdisciplinary Conference in Palm Desert, CA. We came away from that 3-day seminar energized and committed to do something different for women with breast disease in our community. Thus, the weekly pretreatment breast conference began in early 1996.

Immediately, most of the physicians who treat breast disease began participating in the prospective breast conference. Over the years, there has been a steady attendance of surgeons and members of all oncology groups, both radiation and medical. We have tried to accommodate the surgeon's operating schedule, and have found that a Friday 12:30 PM meeting works best for most physicians. The primary goal as a prospective breast conference is to present all pertinent mammography images, followed by a chronological presentation of breast pathology reports, each listing all pertinent diagnoses. The last and most current pathology report, in addition to all diagnoses, includes digital pathology images. Both mammography and pathology use digital photographic techniques, and each presentation includes the respective material using two laptop computers, with a digital overhead projector if needed. We began using a high-definition, large-screen monitor for the presentation, but have moved to a larger room, and now project all images and data on a large wall screen.

What follows after the workup presentation in appropriate cases is a lively discussion from the medical and radiation oncologists. Everyone is keenly aware of the perils of over- and undertreatment. In DCIS cases, the Van Nuys Prognostic Index is calculated and discussed. Likewise, with early stage disease, Adjuvant! Online is used not only in the private practice offices, but is on most of the medical oncologists' and some surgeons' Personal Digital Assistants and used at the conference.

Seeds for Germination

Occasionally, the hospital-based conference has drawn interested physicians from nearby hospitals, usually to present a problem case. Because the regularly attending physicians also practice at other hospitals, word effectively spread that the forum is a friendly place to present a case, and receive what amounts to a timely, prospective second opinion. This happenstance did not go unnoticed. Several times, surgeons from another nearby hospital have been invited to attend our Friday conference, but time constraints and the conference time were not usually convenient for them. But we did not forget the idea.

In the Fall of 2003, a very energetic new physician from a nearby hospital began attending the hospital conferences. This physician's enthusiasm, coupled with the weekly conference experience, evolved into the development of a geographically expanded conference focusing on surgical case management. The format was different from the weekly conference. Instead of prospective treatment planning, the point of the new regional conference was to be a learning experience along the lines of "this is the way I approached this case, and I will never do that again."

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This style of presentation required a very collegial atmosphere that had already been achieved, but now it was going to be used in other hospital–physician settings where no weekly conference existed before. We recognized the challenge ahead—to overcome the very real competitive nature of private practices based around a given hospital and the hospitals' proprietary programs. Not only were we asking breast disease treating physicians to be collegial with their counterparts from other hospitals, but we were also asking competing hospitals to view this physician activity as benefiting each institution as well as all of the women in the community. To start the conference, it was decided to rotate the conference between three hospitals that were roughly 10 miles apart.

Due Diligence

As the conference began to take shape, but several months before the first conference, we visited with key physicians at each of the three hospitals to make sure physicians at each hospital would participate. It was also important to verify that each hospital was supportive of the meeting and its purpose. Three hospitals were selected because of their relative geographic closeness and the fact that many of the breast team members, especially the oncologists, traveled to each institution. In effect, there already was physician cross-pollination.

The guiding principles were that this conference was voluntary and that it would feature problems and solutions faced by practicing community physicians who were taking care of breast cancer patients. Furthermore, the conference was to have first-class presentations of patients' breast imaging studies and pathology specimens. All cases to be presented would have digital images incorporated into a PowerPoint format, and be projected onto a large screen. Above all, the conference we envisioned would be informative, practical, and collaborative. In such a collegial atmosphere, we could also expect that the conference would build bridges professionally as well as personally, and, along the way, might just be fun.

Process Becomes Product

The first multihospital conference began in November 2003. Five cases were presented. Representatives from all three hospitals, and specialists from surgery, radiation and medical oncology, plastic surgery, breast radiologists, and pathology were in attendance.

Since the beginning, the conference has rotated among the three hospitals, each time meeting in a conference room that seats about 25 to 40 people. The meeting was originally designated as physician-only to encourage frank discussions. After the first year, that rule was relaxed because other interested breast center professionals wanted to attend, and we welcomed them. Even with nonphysicians in attendance, the focus of the conference continued to be on problems encountered and lessons learned.

Attendance varies depending on which hospital is hosting the every-other-month conference. The one thing that does not vary is the enthusiasm of those who attend and participate in the discussion. There has never been a boring meeting. There is always more than one topic to discuss and debate.

One interesting evening, a case was presented that had been reviewed at a prestigious academic medical center. Our pathology group did not agree with their consultation diagnosis. Because of the Internet, and the professional friendships made at meetings such as the National Consortium of Breast Centers[1] and Dr. Laszlo Tabar's Interdisciplinary Breast Conference,[2] we community practitioners were able to send pathology microscopic images to well-known breast pathologists, who after reviewing the images, supported our diagnosis. This kind of presentation is not to pursue "US versus THEM" (ie, private practice community physicians versus academic professors), but serves to underline that, in the community, there are well trained physicians who are committed to excellence in their practice. This community-based excellence is particularly important since over 85% of the women with breast cancer in the United States are treated in the community by private practice clinicians, not in academic centers.

As we continue to meet, we present cases which will stimulate discussion, honestly describe shortcomings, and hope that everyone leaves the meeting with a sense of satisfaction and accomplishment. The hope is that the incoming tides of learning benefit all in attendance—raising all boats at the same time—learning that will benefit women with breast disease in the community.

Struggles Along the Way

Behind the scenes of a voluntary conference, different personalities and perspectives of certain physicians sometime create unexpected complications, often referred to as Onco-Politics.[3] Fortunately, there are committed and talented physicians who want this regional program to continue. Because of their enthusiasm and commitment, these physicians have performed as "pinch hitters" on more than one occasion. As an example, in the beginning of the conference, each hospital had a different pathology group. We quickly learned that one group would not attend any meeting, but would send the histology slides for someone else to photograph and organize into PowerPoint. Another pathology group took poor photomicrographs and had a nurse collate the images. This matter was solved by another pathology group performing much of the others' presentation work. Over time, the pathology issues have been, for the most part, resolved. The breast radiologists, on the other hand, seemingly have problems being in each others' venues, but the expressed reasons vary. What happens in a voluntary setting when the pathologist or breast radiologist does not prepare and present the breast findings in an appropriate manner is that someone else must "pinch hit" to fill the void. When the hospital team diagnostic presentation is incomplete, members of that team have reason to be embarrassed. In contrast, when a clinician decides not to attend, the consequences are less noticed. So, 2 years later, we are still working to encourage all physicians who participated in a patient's care (especially the surgeons, breast radiologists, and pathologists) to shed whatever reservations, real or imagined, that prevent them from providing a high-quality diagnostic presentation and/or attending the conference with their other referring colleagues.

Future Directions

Where do we go from here? As mentioned above, there are still improvements to be made. Difficult case presentations will continue to be the focus, but speakers will be invited to discuss current advancements. Recently, Dr. Gabriel Hortobagyi was invited to speak on Clinical Applications of Genomic Profiles in Treating Breast Cancer. We also presented two current cases with recent genomic testing results. Before that meeting, when Dr. Hortobagyi spoke at another forum, he suggested the creation of a similar Breast Disease Working Group in other parts of Houston. These would be independent groups that could meet every other month as we do, with a planned yearly grand meeting in the Texas Medical Center. That is an ambitious undertaking, and would require others to organize their physician groups and hospitals to make such an event happen. The good news is that, in the northwest Houston area, the ground work has already been established for a collegial, professional, educational—and fun—breast disease working group.

Whether the idea stays local in the area of northwest Houston, or grows throughout the city, the purpose will remain the same. The goal is to improve care of women with breast disease in our community—through collegial communication among, collaboration with, and commitment to this regional meeting. The hope is that, through open dialogue about successes and misadventures, we can avoid the misadventures in the future. That is the sum and substance of the regional conference. In addition, there is a subliminal message or spirit in these conferences, that in working together and sharing our experiences, we fulfill our obligation to our patients to always seek better ways of caring for them. We are making progress in that direction. We will continue this program because it benefits so many people within our reach, both patients and physicians. This achievement is its own reward.

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Developing Interdisciplinary Relationships That Make a Difference

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The initial diagnosis and treatment planning of the breast cancer patient's journey represents a critical time when the comprehensive breast center can enhance the communication, collaboration and coordination among the pathologist, radiologist and surgeon. A collegial environment is critical for this to occur. This article describes the co-dependant role among the three specialties - and from the surgeon's perspective, what skills and services are required of radiology and pathology to assure appropriate treatment planning. Among the many issues discussed are the imaging work-up, the clinical breast exam, specimen radiography, specimen processing, triple test correlation, communication of radiology and pathology findings, and patient communication.
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This series of articles about comprehensive breast centers underscores how the treatment of breast cancer has changed so significantly. Historically, it was the surgeon who diagnosed and treated the breast cancer patient, but the day of the "Lone Ranger" has passed. The ability to provide the highest quality breast care is now dependent on functional, codependent relationships and ongoing communication among multiple breast care specialists. In addition to direct communication among specialists, these relationships are enhanced by the weekly prospective treatment planning conference.

Certainly, the existence and importance of these professional interactions continue throughout the life of the breast cancer patient, but at no time are they more important than during the time of diagnosis and initial treatment planning. It is imperative that the surgeon recognize and honor his/her dependence on imaging and histology expertise. Development of this codependent synergy is a natural by-product of the interdisciplinary pretreatment conference, the cornerstone of most comprehensive breast centers. This may be a new concept for surgeons who currently are not working in such an organized, focused environment. That being said, what should the surgeon expect from the breast imaging specialist and the pathologist?

Ideally, the breast problem is identified on a screening examination. Screening examination reports should be brief, using BI-RADS categories. Any perceived problem must be addressed

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