

Advancements in Breast Cancer Treatment: A Dialogue with Our Experts

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♪ [music] ♪ - [Matt] Welcome to "Sansum Speaks", an educational speaker series presented by Sansum Clinics Women's Council.

My name is Matt Bauman. I serve as the vice president of oncology for Sansum Clinic and today, we're going to be focusing on advancements in breast cancer treatment. As many of our listeners know, breast cancer impacts the lives of one in eight women in the U.S. And the two physicians that you're going to hear from today work within Ridley-Tree Cancer Center in Santa Barbara, California, where one in four of our cancer patients have a breast cancer diagnosis.

We know that the impact of breast cancer on our community highlights the importance of conversations like today. We want this to be informative but also encouraging. We believe that knowledge is power and that finding the right team and experts to partner with on your cancer journey are key to your success. I'm going to introduce you to two of those experts but before I do I just want to set a quick baseline by introducing you to three of the primary physician roles involved in cancer treatment.

There are many other physicians involved in cancer care but the primary three physician roles in cancer treatment are our medical oncologists, our surgical oncologists, and our radiation oncologists. Our medical oncologists are experts in treating cancer through the use of medication, the most common of which is chemotherapy, but there's also hormone therapy and immunotherapy.

Our surgical oncologists are experts in removing tumors through surgical intervention. And, our radiation oncologists are experts in treating cancer through precise radiation therapy. Today we're joined by Medical Oncologist Dr. Chad Guenther and Radiation Oncologist Dr. Shane Cotter as we delve into the latest advancements in breast cancer treatment within their respective fields of oncology.

Dr. Guenther recently joined our team from University of Wisconsin Hospitals and Clinic, where he completed his Hematology-Oncology Fellowship. Prior to that, he completed his residency in internal medicine at the University of Texas

Southwestern Medical Center and received his medical degree from the University of Wisconsin School of Medicine and Public Health.

Welcome, Dr. Guenther. Dr. Shane Cotter has been a practicing radiation oncologist with Ridley-Tree Cancer Center since 2012. He also serves as our Director of Radiation Oncology Research. He earned his PhD in Molecular and Cellular Biology, as well as his medical degree from Washington University in St. Louis. He completed an internship at our local Santa Barbara Cottage Hospital and a radiation oncology residency at Harvard Medical School, where he also served as the chief resident. Dr. Cotter has also served on the faculty at Harvard Medical School and the Dana-Farber Cancer Institute. He was an instructor in radiation oncology at Brigham and Women's Hospital until he joined the Cancer Center again in 2012.

Welcome, Dr. Cotter. So let's get started. Maybe first to you, Dr. Guenther, why did you choose to pursue medical oncology?

- [Dr. Guenther] I really like medical oncology. I like science. I like the science behind it. I like how much the field is moving, particularly nowadays. But what I like about medical oncology in particular is that you get to form these long-term relationships with people.

You see people for a lot longer than the other types of oncologists. And you really get to know people and know their wishes and know what they want to do. And, you really get to earn someone's trust. And having that trust is something that's very fulfilling and makes me feel very special and very honored.

So getting to know my patients and spending that time with them is really important to me.

- Appreciate that. And the same question to you, Dr. Cotter, why did you choose the field of radiation oncology?

- [Dr. Cotter] Dr. Guenther, I thought that was really special and well said. I think I'm a lot of the same reasons. So I think the biggest question for me initially was oncology on the whole. And just to be a part of a team that helps to care for patients and their families at such a critical juncture in their lives just is super rewarding and it's a wonderful privilege to have.

And I think I share that with the surgical oncologists and medical oncologists and all the staff here in that same way. And so I think you take that home each day and you can feel really proud of doing that in your career and working with

a team that does that. And it's just really special. Radiation oncology specifically, I was drawn a little bit as we'll touch on later to the technology of the field. It's advancing.

We have wonderful and exciting equipment that we use and each case is unique. And in being so allows a special challenge to each case which I also find quite rewarding. So I truly enjoy, I'm happy I chose to field of radiation oncology and hope to be able to do it for much longer.

- And Dr. Cotter, we read in your bio that you have a PhD in Molecular and Cellular Biology in addition to your medical degree. Can you tell us a little bit about that transition? Or maybe that was happening simultaneously. It seems like a pretty unique educational background.

- Yeah, it is generally unique. I'm a partnership with four total radiation oncologists. Three of the four of us have MD-PhDs. And I think it sort of leans towards the idea that we're interested in sort of the technology and the science behind these things and tends to draw us towards the field of radiation oncology. I studied microbiology.

And during my time at Harvard, I also did some research looking into viral tumors, how viruses help to cause cancer, and how they might respond differently than other cancers in that way. So there's just a nice interrelationship between basic science and oncology generally. Dr. Guenther, I'm sure, will talk some about that in terms of the types of amazing new drugs that are on the way based on these findings. So it transitions nicely into the field. At this point, I don't do any more basic science. But we are involved in research, as we'll talk about a little bit later on.

- Makes a ton of sense. Thanks, Dr. Cotter. Dr. Guenther, I think that's a good, good segue into the latest developments in breast cancer treatment. Can you tell us a little bit about the latest developments in breast cancer treatment, but specifically to medical oncology and what your experience has been maybe in the last five or so years?

- There's been a lot of developments in the last five years, but a lot of developments as is often the case are developments where we are standing on shoulders of giants.

And I think it's important to consider where were we before, which was in the 1970s, we had chemotherapy. And that's what people think about when they think about medical oncology and breast cancer in general. And I think where we're heading now is moving further and further away from that if we can. Over

time, we've learned about breast cancer subtypes, about particular markers that help us predict what someone might respond to and how well.

And so I think I'll focus some of this answer on treatments that we give before and after breast surgery for cancers that are localized to the breast and maybe lymph nodes nearby, meaning they're not metastatic and widespread. There's special names for treatments that are done before or after a surgery that you might hear.

A treatment before a surgery is called neoadjuvant. Neoadjuvant. And a treatment done after a breast surgery is called an adjuvant treatment. And so the people that might be reading about cancer treatments and see these words come up, this is what they're referring to.

First, let's talk about the most common subtype of breast cancer, which is hormone receptor-positive HER2 negative breast cancer. Hormone receptors are proteins on the side of breast cancer cells that respond to female hormones, estrogen, progesterone, and in response, it causes the cell to grow. And treatments for hormone receptor-positive breast cancer do include things like chemotherapy, which is something that is directly toxic to dividing cells.

It's sort of a controlled dose of a poison. But the more important treatment for a hormone receptor-positive HER2 negative breast cancer is something called endocrine therapy. Endocrine therapy is a treatment that uses medicines that prevent hormones like estrogen and progesterone from promoting the growth of breast cancer cells.

It's also sometimes called hormone therapy, different than what's used in menopause, but also called hormone therapy. And these are pills that are generally taken about once a day for at least five years. One of the biggest developments over the last 10 to 15 years, I'd say, is the development and utilization of these 21-Gene recurrence scores.

The most commonly used one is called an Oncotype DX recurrence score. This is a test that uses a sample of tissue from a surgical specimen. And it evaluates genes that are particular to an individual cancer. So it's what's going on in one particular person. And it generates a score ranging from 0 to 100, with 0 generally meaning a lower risk of recurrence and 100 being a higher risk.

Two major trials looked at the Oncotype DX, TAILORx, and RxPONDER, and nearly 15,000 women enrolled on these trials to see and help decide cutoff points for who might benefit from chemotherapy and who doesn't at all.

Generally, what was found that if you score 25 or less, that there's not an additional benefit from chemotherapy.

Running these tests has helped us to avoid over-treatment for people that might not benefit from something that can be hard and something that can be kind of toxic. These are incredibly helpful tests. They also help us to get a better understanding of what someone's individual recurrence risk is, what their prognosis is, and it's helped us to avoid a lot of side effects.

For premenopausal women that have intermediate scores, there's also been a debate in the oncology community as to if there's benefit from chemotherapy. We found that people that have intermediate scores, they seem to do better with chemotherapy. And we have also noted that with chemotherapy, oftentimes the menstrual cycle will stop.

And the open question now is, is chemotherapy actually beneficial here, or is the benefit because chemotherapy stops the menstrual cycle? And so this has driven new research. There's a trial that's occurring right now, occurring meaning people are going on to the trial, person by person, it's called OFFSET.

It's run by a group called NRG, where they're trying to figure out, do people benefit from chemotherapy? Or if we were to give injections that suppress the menstrual cycle and gave endocrine therapy, like we've already talked about, is that just as good? We're hoping to know some data from that, initially in about five years, and I think the trial will finish up in about 10 or so.

And I think that's going to be really exciting information. So we've talked some about deescalating treatment, but what are some things that we can do to escalate treatment for people that might be higher risk with hormone receptor-positive breast cancer? Well, one thing that we found for people that are able to take drugs called aromatase inhibitors, one of the endocrine therapies, is that aromatase inhibitors work better than drugs like tamoxifen.

But unfortunately, women that have not gone through menopause do not have benefit from aromatase inhibitors alone. The drug just won't work based on what it does. We now know that it's possible to give injections to suppress the menstrual cycle and give aromatase inhibitors a drug that works better than tamoxifen to help intensify treatment sum.

And we know this through some long-running clinical trials, including the SOFT trial and the TEXT trial. And, in particular, this seems to especially benefit younger women that have been diagnosed with breast cancer, especially younger than age 35. Another newer strategy to intensify breast cancer

treatment for women with hormone receptor-positive breast cancer is the use of a type of drug called a CDK4-6 inhibitor.

These are groups of drugs that were initially studied in the metastatic setting, in the setting to treat breast cancer that's no longer curable. But what we found is that in certain women and in certain men, they may be at high risk for breast cancer to come back.

And there have now been two studies that have reported out data showing that we can use these therapies in the adjuvant setting after a surgery to intensify the treatment sum and decrease the risk of breast cancer coming back. There's a drug called Abemaciclib that was studied on a trial called monarchE. And there's a drug that was recently reported on called Ribociclib that was reported in a study called NATALEE.

The data on this is still very immature. And we're going to know more about exactly how much of an effect that we have, but the early results are very encouraging. Shifting a little bit from hormone receptor-positive breast cancer and talking about a different subtype, I'd like to talk a little bit about HER2-positive breast cancer.

HER2 is a protein, it's a normal protein found on the surface of breast cells. About one in five women and men have extra copies of HER2. And this tends to cause the breast cancer to be more aggressive, grow more quickly, and often means that chemotherapy is required to have the best outcomes for people. The most important thing for HER2 breast cancer has been the development of antibodies for HER2 specifically.

There was a drug that was developed 20, 25 years ago called Trastuzumab, and this caused a sea change in how people did with HER2-positive breast cancer. More recent meta-analysis looked to see what the overall effect was by adding this antibody to chemotherapy and found overall that there's been a one-third reduction in recurrence rates in breast cancer since we started using these drugs.

More recently, we found other antibodies. There's one that's called Pertuzumab that was studied on a trial called APHINITY that's also been shown in addition to Trastuzumab to improve invasive disease-free survival, which means to improve time where breast cancer has not come back when added to this Trastuzumab antibody and chemotherapy.

We also know from several trials that it's also possible to give chemotherapy before a surgery for HER2-positive breast cancer. And we know that men and women that have treatment that way do just as well. More recently though,

there's been an FDA meta-analysis that showed that we can find some information out about breast cancer and the prognosis of breast cancer at the time of the surgery for people that had treatment before.

There's something called pathologic complete response, meaning that after a treatment that's happened before a surgery, after a neoadjuvant treatment, at the time of the surgery, breast cancer is no longer seen. And what's been shown is that if that's the case, the prognosis is significantly improved. And so a major focus for HER2-positive breast cancer trials has been, what can we do in the neoadjuvant setting to improve the rate of pathologic complete response?

And the second thing we've worked on is, well, what if we can't get there? What can we do for the people that don't get there to improve their prognosis? One of the more recent trials to evaluate this is something called the KATHERINE trial. KATHERINE trial looked at something called an antibody-drug conjugate. An antibody-drug conjugate is where an antibody is linked to chemotherapy to specifically target one particular protein.

This KATHERINE trial looked at an antibody, the same antibody we talked about before called Trastuzumab and linked chemotherapy to it so that this drug targeted HER2-positive breast cancer. And they studied a drug called Trastuzumab and Tansine, or TDM-1. What they found was that giving this drug after a surgery for men and women that did not have a pathologic complete response reduced the risk of breast cancer recurrence or death by 50%.

So this new drug class, these antibody-drug conjugates, are a really exciting development in the field of medical oncology. And there are more and more that are coming in the adjuvant setting on clinical trial, and more and more that are being developed and used in the metastatic setting.

The other type of breast cancer that's treated is called triple-negative breast cancer. A triple-negative breast cancer is a breast cancer that does not have the hormone receptors that we've talked about already, and does not have this amplified HER2. And somewhere around one in 10 breast cancers are triple negative.

Unfortunately, this type of breast cancer has a worse prognosis, and it generally requires chemotherapy as well. And similar to HER2-positive breast cancer, treatment for localized disease, not metastatic disease, has also moved before surgery. And pathologic complete response also is prognostic.

It lets us know more about prognosis afterwards. And some more recent trials that have looked at what do we do afterwards for residual disease. People that

don't have pathologic CR include a trial called CREATE-X, where a drug called Capecitabine, an oral chemotherapy pill, was given to men and women that had residual disease after surgery.

And it increased both overall survival and progression-free survival, meaning cancer took longer to come back if it came back at all. And men and women that received this treatment lived longer. Other newer treatments include the use of immunotherapy in the neoadjuvant setting before surgery and given afterwards.

Immunotherapy is a very exciting development in medical oncology and it's being used in the treatment of several different types of cancer, not just breast cancer. It's also used in the metastatic setting too, but probably the most important development in the neoadjuvant setting has been a trial called KEYNOTE-522 that looked at the addition of a drug called Pembrolizumab, also called Keytruda, to chemotherapy and administration of this drug afterwards.

And what was found that giving this drug increases the rate of pathologic complete response, which we know leads to better prognosis. One last thing I'd like to talk about is the 10% to 15% of triple-negative breast cancer that has a mutation called BRCA1 or BRCA2. We tend to call it BRCA1 or BRCA2.

These are mutations that happen very early on. They're called germline mutations and they predispose to breast cancer and several other cancer types. We screened women and men for these types of mutations to see if it might be possible that they have a higher risk of developing future cancers that are not just breast cancer, a higher risk of recurrence of breast cancer, and also if they're at a higher risk of passing on this gene which would lead to a higher risk for their children to have these cancers.

In addition, there's a class of medications called PARP inhibitors that have been studied in breast cancer with BRCA1 and 2 mutations. And more recently, there was a trial called the OlympiA trial that enrolled patients with breast cancer with BRCA1 and 2 mutations and treated with a drug called olaparib. An adjuvant treatment for one year with this drug led to a significant improvement in overall survival.

So, all together, I have to say that there's been a lot of work done before and after surgery to help people live longer, live better, and be cured. And there's more work to do. There's more work ongoing now.

And I think this is just a really exciting time to be a medical oncologist and see what is found out now and what we can do to help people.

- Dr. Guenther, that's incredibly comprehensive and super informative. You know, if we think about the impact from a patient or maybe family member's perspective, a couple of key words I think stuck out from your summary in recent, let's say five-year advancements in breast cancer treatment, those key words for me at least were treatment ahead of surgery, right?

I don't think that's something that would be intuitive or common. Another thing that you mentioned was de-escalating care. I don't know that we typically associate de-escalation of care with cancer care. And then immunotherapy, which has certainly been a hot-button topic as of late.

Dr. Cotter, I want to kick this question to you. When you think of a term like de-escalating care, how has the de-escalation of care made an impact in radiation oncology in your field?

- I think it's a great question. Dr. Guenther, thanks so much for that. That was amazing. So just maybe to step back a second and orient folks to what radiation oncology is. So the job of a radiation oncologist is to aim radiation at the places where we think there's a chance there might be microscopic disease left behind after surgery and after chemotherapy when needed or given.

And so we have to determine how big we think the risk is that there might be something left behind to determine if the radiation and the insurance it provides is appropriate given the possible side effects of radiation treatment.

So often we will give radiation therapy after a woman has a lumpectomy, although we'll come to certain situations where we might not. And then we'll often consider radiation even after mastectomy if the patient is shown to have their lymph nodes involved or other high-risk features. I will say that in terms of the radiation we provide, there are certain situations as Dr. Guenther described, where we can subdivide patients into certain categories that are at lower risk.

In the same way you're often able to avoid chemotherapy, there are situations where we may be able to avoid radiation therapy. Similarly, in regards to de-escalation, there are some patients we think now that respond so well to these advancements in chemotherapy, especially when given before surgery so we can see how they respond, that we are starting to wonder whether the risk is low enough even with a lumpectomy that we might be able to avoid the need for radiation in those settings.

So de-escalating how often we give radiation is one component I'll talk about a little more in a bit. And then the second is when we do decide to give radiation, there have been significant improvements in our technology in radiation

oncology that allow us to target that radiation in ways that is more specific and allows us to avoid other structures that are close by or even perhaps avoid treating parts of the breast we don't need to.

So we can de-escalate in how we give the radiation when we give it, and perhaps even de-escalate in giving it at all, given the rapid and market improvements in what Dr. Guenther has just described. So I think that would be the background I'd put it in. To talk about how we might de-escalate a bit in regards to side effects, there are two ways we do this. One is that for breast cancer, there is a technique called accelerated partial breast radiation that's been in significant practice over the last 10 years.

And the idea there is there are certain patients where the tumor is thought to be small enough and localized enough that the majority of the breast is not actually at risk. The lymph nodes aren't at risk, other parts of the breast aren't at risk. The way I would describe it to patients is that a tumor is in Maine. It's really unlikely it's going to make all the way to Florida or California.

And so you can really just treat that portion of the breast over often just one week with studies that have shown with up to 10 years of follow-up now, essentially equivalent side effect profiles, or sorry, excuse me, with more than five years, nearly 10 years of follow-up on these trials, equivalent outcomes in terms of low risk of recurrence with very low side effect profiles.

So we often use accelerated partial breast in our practice here for patients who are considered appropriate for that technique. Another example is anytime we need to treat the entire breast or the lymph nodes on the left side, for many years, there was an increased risk of heart disease because the radiation in order to treat the breast would also touch the heart.

Now we do CAT scans to prepare for radiation. We can see exactly where the heart is, we can shape and angle the radiation away. And probably the biggest advancement in this regard most recently is something called deep inspiration breath hold technique that we use in practice at our institution since opening this new center about five or six years ago.

This technique allows us to in real-time watch a patient take a very deep breath and only have the radiation beam turn on when that breath has been taken in a way that creates additional space between the breast and the heart. When a patient standardly lies for radiation, the breast is here and the heart is here, but when they take a deep breath, the chest rises and the heart is pulled down by the diaphragm.

such that they separate in such a way that you can treat the breast and not touch the heart at all. And so that is a technique that has allowed us to sort of de-escalate the side effect profile of radiation markedly. And we use that for all of our left breast cancer patients now.

- A quick follow-up question on that, Dr. Cotter, is that a technique thing or is that a technology thing?

- I think it's probably a combination of both. A deep inspiration breath hold treatment is a technique enabled by a technology. So our technology, our center is called Vision RT. It is a system that's installed in both of our treatment rooms that allows us to see in real-time, the patient's anatomy on the table in space to millimeter measurements.

And so we're able to have that technology in touch with our machine, such that only when the patient's chest rises to the correct location, where we know where it is, it's how we planned it to be, only then can the radiation machine turn on. So in practice and treatment, a woman will take four or five 15 to 20-second breath holds to get through the treatment.

If a patient coughs and loses their breath during the treatment, the machine automatically turns off instantaneously. We just resume back where we were. And so we have great confidence that when that radiation beam is on, that the heart is not in the path of it, to decrease any risk to the heart long-term. So it is a technique that is only possible given the technological advancements over the last several years to allow us to do it confidently and safely.

To piggyback a bit off Dr. Guenther in regards to these different treatment types, I would want to touch on two areas of de-escalation in delivery of treatment that we're pursuing at Ridley-Tree now. These are two NRG trials that we have open at our institution. One is called the DEBRA trial and one is called the HERO trial.

And all these trials have names now and I try to get people to remember we're going to talk about monarchE and NATALEE and now DEBRA and HERO. The first trial, DEBRA, is de-escalation of breast radiotherapy for women with ERPR-positive disease with very low Oncotype scores. Dr. Guenther touched on the idea of an Oncotype score to determine whether chemotherapy is needed, but it also gives us information about how likely a breast cancer is to come back after lumpectomy if radiation is not provided.

So we have learned over the course of the last 10 to 15 years that women over the age of 70 with ERPR-positive tumors of otherwise low risk based on

multiple pathologic factors can often forego radiation therapy if they go on one of the anti-hormone pills that Dr. Guenther described with no change in their long-term survival.

So initially that was age 70 and older, there was a recent study called the PRIME II Trial for 65 and older, and the trial we have open is for anyone over the age of 50 to consider avoiding radiation all together if they have a low Oncotype score, negative lymph nodes, and other low-risk pathologic features. So that trial is offered in our institution to try to avoid radiation therapy with the idea that this might be the type of patient who is at such low risk that the insurance of radiation may not be needed.

The second trial is for HER2-positive patients, as Dr. Guenther described the sea change as the drug Herceptin came online and the multiple additional HER2-related therapies. In this case, primarily for patients who undergo neoadjuvant chemotherapy and have that pathologic complete response that Dr. Guenther described and pursue a lumpectomy, the question is, if everything melted away with that surgery, how critical is it to give radiation to that breast if we were really hopeful that everything is in fact gone?

So the standard of care remains to give radiation therapy after a lumpectomy for HER2-positive disease. But this trial asks the question of whether or not we might be able to avoid radiation completely for these patients.

So the trial, the HERO trial, half the women get radiation as standard, the other half do not get radiation at all. There is a second arm to that trial for women that have chemotherapy after surgery, as long as the tumor is quite small and they receive all of their HER2-directed chemotherapy, they can also attempt to avoid radiation on this trial.

So these are two examples of subtypes of breast cancer patients where we are actively looking to de-escalate the radiation as the systemic therapy that Dr. Guenther provides has improved because this is overall a team approach, surgical oncologists, radiation oncologists, medical oncologists. Our goal is to provide the least side effects with the highest rates of cure and as other things keep improving, sometimes we may be able to do a little less on our end.

- Dr. Cotter, that's super helpful. I've seen the two of you, both, together within our cancer center. You talk about the team approach to cancer care with really three parts represented. Can one of you talk about the impact of a tumor board to an individual patient's cancer care? Maybe Dr. Guenther, if you could start.

- A tumor board here at Ridley-Tree is held once a week. And what a tumor board is, is a place to present individual cases, individual circumstances for people that are working together on the team to come to the same table and discuss care and coordinate in first person and coordinate live, to be honest.

We look at pictures, we look at mammograms, we look at ultrasounds, we look at MRIs. We see right where the cancer is, and we see where the biopsy is. Where will the surgery take place? What will be targeted with radiation? And we share ideas of, how would we manage this?

It's not just one medical oncologist and one radiation oncologist that's there. There are several and you hear the opinion of the medical community. Sometimes that opinion is the same amongst different providers, but sometimes they're a little different because there can be a little bit of art to medicine too.

We have the help of some phenomenal doctors as well, some excellent breast radiologists who are also part of this team, some excellent pathologists that review everything that they see under the microscope with us. So I don't want to say that oncology is just those three fields because it's really a wide field. And there are so many people that are coming and helping people.

- Dr. Cotter, great point on this really being a team effort. You led, for a while, our breast cancer tumor boards. Can you talk about maybe what that experience is like, but even more so what's the desired outcome from a successful tumor board from the perspective of an individual patient who's been discussed in that setting?

- Sure. Yeah, I ran the breast cancer tumor board for I think a little over five years. I've since passed the torch, but still attend every week, just not master of ceremonies, I suppose, anymore. The tumor boards are very helpful. So cases are brought forward by one of the doctors on the team to be presented in front of surgeon, medical oncologist, radiation oncologist, genetic counseling, nutrition.

All these folks can be on this call to sort of talk through the nuances of any specific case and often essentially to sort of set the table, so to speak, in terms of what the best approach is going to be in terms of what needs to come first. Perhaps this is a case where chemotherapy may be the best first option. How would that implicate or change radiation therapy plans? How might that change surgical options? And sort of talking through the different paths of approach for each case in a way that allows us to optimize it as a team in real time.

And I think that's extremely helpful for a patient to get all the thoughts of the different people who are going to be interacting in that patient's care on the

same page early on to allow us to make the best choice and choose the best path to walk along with that patient.

- Dr. Guenther, can you talk a little bit about in this tumor board environment, how often do you come in maybe with one plan and leave with a slightly adjusted plan based on that collaborative discussion over a single patient case?

- I think that happens fairly frequently, to be honest. I think that hearing the perspective of how one thing can be managed on the back end, like what will radiation be able to do or what will be a plan of surgery or lymph node dissection or otherwise, I think is helpful and it helps me to tweak what I might offer.

- I will add that I also find it very educational. As a radiation oncologist, it gives me exposure to what the surgeons are thinking, to what the medical oncologists are thinking. It's wonderful to hear discussion amongst the multiple medical oncologists about the options that are there. You can see how quickly that field is evolving.

And it allows the rest of us to sort of keep up the speed to some degree with what's happening in these other subspecialties of care.

- That's helpful. You know, we often hear about comprehensive breast cancer care. And I think one of the themes that I'm taking away from the conversation today is, you know, we've talked about genetic counseling and their impact in helping us understand gene mutations and how that's going to change maybe our plan for a specific patient.

We've talked certainly about our three primary physician groups, but we've also talked about pathology, radiology. There's even nurse navigators, social work, and all the social determinants of health care that come into this setting. Dr. Guenther, can you talk about what it's been like to practice in this truly comprehensive environment where under one roof we have every specialty and every supporting level of expertise represented and accessible, right?

You know, second floor, third floor, they're all still in the same building. What's that been like for you here?

- One word, seamless, I would say. If Dr. Cotter is seeing someone that he knows I'm seeing later in the week or the following week, in one building, he can climb the stairs, come into my office and say, "Hey, this is what I'm thinking," immediately. Or if, for instance, we want to see if somebody as a clinical trial option, those people are right upstairs.

Genetic counseling is right here, too. And everybody's just a call away. And an in-person meeting can happen impromptu whenever. And I think that's something that's really special and really helps women.

- Thanks, Dr. Guenther. Dr. Cotter, is there anything else that you would want our community to know about you or your approach to cancer care?

- I'll follow up with Dr. Gunther just for a second on just being in the same building. I find this super helpful. It is not unusual for me to get a cup of coffee, walk up the stairs, knock on the door, talk about a patient I'll be seeing that day, making sure we're on the same page, making sure if I want to communicate something specific about a thought I had about a patient I saw earlier in the day. It's also not uncommon to have a patient that's recently had chemotherapy and that patient might have a question for medical oncology that happened to be seeing me and we can make a seamless interaction with them and medical oncology team to sort of address any of those concerns because they're here and we're seeing them as well.

And we're all part of the same big team. So I find it super helpful to all be here together in this regard, surgery, medical oncology, and radiation. I think it's a real benefit to the patients.

- Very fair. And I, you know, what is the team maybe that represents the unsung hero in that experience? You know, not the, not the frontline physician roles, but is there a team that stands out to you that's impactful? And this doesn't need to be, you know, a ranking, but one team recently, that's maybe been impactful to you that our audience maybe doesn't know exists in this cancer center setting.

- I think in terms of this seamless care, the medical assistance and nursing team end up doing a lot of the communication. I feel like there's a hotline between the floors for these folks, and they'll be able to get people in quite quickly and address these issues very quickly in a way that doesn't inconvenience the patient, allows to get answers and help the patient make sure that we take care of them as is appropriate at all times.

- And how about the response, Shane, to the additional ancillary service, the supportive care, integrative care component. Is there a team that represents, you know, that's somewhat of this unsung hero, somebody that's been highly impactful to patient care, but doesn't maybe make the front headlines of a clinical research study?

- I think another one of the teams at the center that is super helpful in terms of providing holistic and seamless care, I would say is our nutrition team. I think

it's hard not to talk about that in terms of what impact we have. We're talking mostly about breast cancer today. There are, in terms of chemotherapy agents, Dr. Guenther can probably talk about this a bit more, that they allow that treatment to go more easily with less side effects.

There's long-term implications around diet and dietary changes to decrease the risk of recurrence of breast cancer that our team is in to follow these... that the nutrition team is involved in to help long-term, even after the patients are done with their radiation treatments and beyond.

- Dr. Guenther, any unsung hero in your mind, any group that stands out for you that's come in to make a big-time impact on either the quality of care or the comprehensive nature of the care that you offer?

- Two groups, I'd say that are often unsung, but our patients love them. The first is the navigators that we work with. Navigators are assigned to individual patients and they follow along to make sure that things are being scheduled. Patients know where they need to be somewhere, when they need to be somewhere. They give reminder calls.

They're a fast phone number to call if you need to get a hold of us faster. They help us get orders in quicker and help us fill in all the boxes that need to be done to deliver treatment in the best way and in the most efficient way. The second group I'd like to talk about are social workers.

And I've had very positive interactions with them because as Dr. Cotter talked about, and I think you've talked about this too, Matt, there are things that are upstream of just cancer treatment that can make it really hard to do well.

What happens when you have to take off work and you can't go to work? What do you do? How do you file for disability? How do you fill out that paperwork? Who do you turn it into? What happens if you're diagnosed with breast cancer and you're in school and you're a very young woman? How do you withdraw from school? How do you go back?

And what happens if there's a copay that you need some help with and you need to fill out paperwork and you don't know what these things are? And I think in particular in these areas, these upstream areas of what we're, before we see people, social work is really helpful. And I'm really appreciative of them as well.

- Maybe a final question here. Is there anything else that you would like our community to know either about you or your approach to breast cancer care? And maybe let's go with Dr. Guenther first.

- I think my approach is to be open and to be honest, to share what we're finding, to say what I think. In my interactions with people, people are appreciative of someone that lets you know what they're actually thinking.

I think that that's what you'll find when you come and you come talk to me and other medical oncologists here.

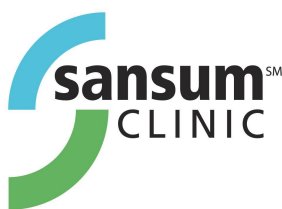
- Thanks and Dr. Cotter, anything that you want our community to know about you or your approach to breast cancer care?

- I think just pretty simply that I'm proud to do this for a living. I'm proud to be able to help care for women and their families with breast cancer. And I'm proud to be part of this team that allows us to do it in the way we do. I think as simple as that.

- Yeah, it's a pretty special place to be. It's special when we're in this community and we hear about successful treatment stories of patients that have seen actually in my neighborhood, my neighbor, a patient of Dr. Guenther, and my table mate at a recent dinner, a patient of Dr. Cotter. And it's just pretty spectacular to see successful breast cancer care stories.

In wrapping this up, I hope that this has been a reminder for everybody listening that there's always hope in our breast cancer care journey. Early diagnosis and medical expertise like you've listened to today are key to that successful journey. We here at Ridley-Tree Cancer Center and at Sansum Clinic, we're here to partner with you.

We appreciate you taking the time to join this episode of Sansum Speaks. We hope you found this to be valuable information. For all of our other talks, please feel free to visit sansumspeaks.sansumclinic.org. And, again, thank you for joining us.



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