

Surgical Options for Breast Cancer

October 28, 2009

Kristine Calhoun, M.D.

Suzie Hagerland

Please remember the opinions expressed on Patient Power are not necessarily the views of Seattle Cancer Care Alliance, its medical staff or Patient Power. Our discussions are not a substitute for seeking medical advice or care from your own doctor. That's how you'll get care that's most appropriate for you.

Introduction

Andrew Schorr:

Surgical options for breast cancer can leave some women feeling overwhelmed. What's the right decision? Should it be breast-conserving surgery? Are they a candidate for that, or should they have a mastectomy? Well, join a Seattle Cancer Care Alliance breast surgical specialist for a better understanding of what options are available at various stages of the disease and one of her patients who has just undergone treatment. It's all coming up next on Patient Power.

Andrew Schorr:

Hello and welcome to Patient Power sponsored by the Seattle Cancer Care Alliance. I'm Andrew Schorr. Well, if a woman is diagnosed with breast cancer very likely, not always, but very likely surgery is one of the modalities that's pursued. When is it appropriate, and how extensive will that surgery be? Will one surgery be enough? And how do you decide through all this, and who can help you? It can be overwhelming.

Well, these are the decisions that were faced by Suzie Hagerland of Mercer Island, Washington, when she found that she was dealing with breast cancer. Suzie, thank you so much for joining us on Patient Power.

Suzie:

Thank you for having me.

Andrew Schorr:

So, Suzie, you are 46. Is that right?

Suzie's Story

Suzie:

I am 46.

Andrew Schorr:

And you have a young daughter, three and a half. What's her name?

Suzie:

Her name is Cassidy.

Andrew Schorr:

All right. So not all that long ago Cassidy ended up playing with you and jumped on your chest. What did you feel afterwards?

Suzie:

Well, it just frankly felt very strange, and I knew right away that I should follow up and have something checked out.

Andrew Schorr:

And it ended up that you had a lump that needed to be investigated further?

Suzie:

That's correct.

Andrew Schorr:

So you go through ultrasound and I guess ultimately a biopsy, right?

Suzie:

I did the ultrasound followed by a biopsy, and then a phone call with the results, which were that I indeed did have cancer.

Andrew Schorr:

And so often women are told, oh, it's just a cyst or it's probably nothing, but you're in a minority of the time when it is told you have cancer. So you and your husband then started to say what is the wisest healthcare team we can put together. That brought you to the Seattle Cancer Care Alliance. First of all, what attracted you to them?

Suzie:

There was a combination of factors, one of which my employer was going through a transition in insurance plans so I wanted to make sure that the old plan and the new plan, I had a doctor that was covered under both because the transition time would be after I started my treatment. And I wanted to find the right person for me or the right team for me. I ended up at Seattle Cancer Care Alliance in large part because they take a team approach, and I like the fact that it was more than one person looking at my case and making, looking at options for me and presenting recommendations for me. So knowing that along my treatment I would have someone at each stage that had primary responsibility but they had someone else kind of weighing in in the decision.

Andrew Schorr:

I'm all for that too, a the team approach. It makes a lot of sense. Now, in your case we should tell our audience that you went on through surgery, and we're going to talk about that in a soaked, and on to chemo, and you just like about an hour ago completed your first of 24 cycles of chemotherapy, right?

Suzie:

I did.

Andrew Schorr:

How are you doing?

Suzie:

Right now I'm feeling great, but who knows what tomorrow will bring.

Andrew Schorr:

Well, thank you for being here. So it became clear in your case that you really did need a team. It wasn't just surgery, that there would be a medical oncologist, a whole team approach made sense to you.

Suzie:

Absolutely.

Andrew Schorr:

So let's talk about surgical options. So you knew you were going to need some surgery. There was a biopsy done to understand what you were dealing with?

Suzie:

So the initial biopsy to determine that I had cancer, and then once I met with the team recommendation to do some further studies that then led to a biopsy of my lymph nodes.

Andrew Schorr:

All right. Well, let's bring in your surgeon who is a member of that team, and that's Dr. Kristine Calhoun. She is a breast surgeon at the Seattle Cancer Care Alliance, also an assistant professor at the University of Washington. So, Dr. Calhoun, let's get to that situation. Suzie, I bet with the diagnosis of breast cancer you just wanted it out, right? That's the typical feeling.

Suzie:

I wanted it out, and I also, because I'm kind of a planner by profession, wanted to know exactly what date it was coming out.

Andrew Schorr:

All right. And so, Dr. Calhoun, I'm sure you hear that all the time, that people want to plan. But also there's an urgency, but you need to do these tests to know what you're dealing with. Tell us what you did in Suzie's case. First there had been the biopsy to confirm it was cancer, but then there was further tests to determine what you were dealing with. Help us understand why that's so important to make what you do as a surgeon right on target.

Dr. Calhoun:

Absolutely. First, I'd like to say thank you for allowing me to participate today and also thank you to Suzie for sharing her story. As she mentioned, we do have a team approach, so when she came in we recommended, the medical, the surgical and the radiation oncologist had recommended an MRI. And that MRI actually

showed that some of the lymph nodes on the side where she did have her breast cancer in the axilla or the armpit looked a little bit different than on the other side. So that led to an ultrasound, which ultimately led to a biopsy. And in her situation it was actually very important because it allowed us to actually skip one what would have been unnecessary step of surgery and just go to a more complete lymph node removal. And so it really helped formulate a final surgical plan and really eliminated some unknowns.

Andrew Schorr:

How do you explain the options to patients? Suzie had one situation. Let's talk about how you explained the options Suzie, and then we'll talk about somebody where maybe their situation is a little different.

Explaining Surgical Options to Patients

Dr. Calhoun:

So for Suzie, she actually did have two options. For breast cancer we have for most patients the option of both lumpectomy, which is followed by radiation, as well as mastectomy, and this is really in terms of how we're treating the primary breast cancer and not really the lymph nodes. Some patients have two options, and she was fortunate. She had a cancer, which we did feel we could get completely around with partially breast removal or lumpectomy. But she could have chosen a mastectomy, and really what I feel for a patient who does have both of the options I explain the pros and the cons of both approaches, and then once I've provided them with all the information I ultimately leave it up to the patient to make the decision which option appeals to them the most.

Andrew Schorr:

Suzie, let's talk about your decision. What were you thinking should be done?

Suzie:

I'm fortunate in some respects that my mother had gone through breast cancer eight years ago, and she had a lumpectomy, and so I had experience with what a lumpectomy could result in, and that helped me make my decision. It also helped to understand the pros and cons of a lumpectomy versus a mastectomy combined with the rest of the treatment. So my understanding of the complete treatment program as opposed to the specific just the surgical part was a key factor in me making my decision to have a lumpectomy. And because of the size of my tumor, the type of cancer, lumpectomy was a choice for me, and that felt, to both me and my husband it felt right. And my husband was very gracious in really letting it be my decision and helping me weigh through the pros and cons, but not trying to, not trying to influence me in one way or another.

Andrew Schorr:

Doctor, so a lot of women then hear options from one doctor and they go and get a second opinion. How do you feel about second opinions, because here a woman says, these are my breasts. They're real important to me. Yes, I want to get rid of the cancer. I want to have the minimal surgery, usually, that's required, although

we'll talk about women who want to have more aggressive surgery. So how do you feel about second opinions, first of all?

Importance of Second Opinions

Dr. Calhoun:

I think that they are absolutely vital, and I always give my patients the option of a second opinion. I think the only physician you need to be leery of is someone who tells you, oh, you don't need a second opinion. I think those are the physicians who you need to watch out for. So I often am giving second opinions, but if a patient of mine opts to get a second opinion if I'm the first treating physician that they've met, absolutely I will provide them names, and I completely leave it up to them. Because ultimately you're going to have a relationship that's long standing with this person, and I really want the patient comfortable with me as a provider and as a person. And if I'm not the right person for that patient, then I will help them find someone who is.

Andrew Schorr:

Dr. Calhoun, what every woman wants to hear when you've done breast surgery is afterwards say, like in the case of Suzie or whoever the woman may be, well, I'm confident we got it all. And certainly you're having a pathologist look at specimens you're giving them, I guess maybe even while the surgery is still going on. But in Suzie's case, you weren't sure, right? Help us understand that.

Dr. Calhoun:

Right. And that's one thing that in terms of one of the cons of a lumpectomy is the patient who comes in and says I want one surgery and one surgery only. I never can promise that I can get that with the lumpectomy with the first surgery, and it's really because we have a target that we're going after. The radiologists help us with putting in wires to really guide us because oftentimes these really aren't palpable or we can't feel them. So there are steps that you can take in the operating room, but it really comes down to the pathologist microscopically telling you if your margins are clear, and that's really what the key with a lumpectomy is.

And I'm very open and honest with my patients, and I tell them that 10 to 20 percent of the time with the first lumpectomy we won't, quote, get it all, and that's really not something that can be sorted out during the surgery. That really takes an additional four or five days of looking at the tissue by the pathologist. So unfortunately I do occasionally have to call a patient up and say, we got the bulk of it but we need to do a little bit more breast surgery, and in Suzie's case that was in fact what I did need to tell her.

Andrew Schorr:

Suzie, were you prepared for that?

Suzie:

I was, I was actually somewhat surprised because I didn't think of myself of being one of the 10 to 20 percents. But I mean Dr. Calhoun gave me the news in a very

good way and it, you know, after kind of talking through it didn't devastate me. So it was unfortunate, but it's understandable. I also at that point was so focused on my drain that I didn't really care about the second surgery.

Andrew Schorr:

Right. I read about this. You just wanted to get the drain out and move on with your life.

So, Doctor, let's go on. So we've talked about Suzie's situation. More broadly, who is a candidate for lumpectomy and who isn't? So if a woman says, okay, I want to have the least taken out as possible, that's not everybody's clinical situation. Help us understand that.

Who is a Candidate for Lumpectomy?

Dr. Calhoun:

Correct. And really the key is the patient who has a lumpectomy also has to be willing to do radiation. So the first patient that I would say you cannot have a lumpectomy to is someone who either refuses or can't have radiation because we clearly know based on long-term data that if a patient has a lumpectomy it doesn't matter how good your margins are, if you don't then do postoperative radiation the outcomes are inferior. The recurrence rate within breast can skyrocket from about 5 to 10 percent all the way up to 30 to 40 percent.

There are unfortunately some women who have large tumors that are potentially involving more than just one portion of the breast, that are what we call multicentric or involving multiple areas or quadrants of the breast. Those patients unfortunately can't have a lumpectomy. And then there are some women who have smaller breasts with very large cancers, they are not felt to be the best candidates for lumpectomy either. And then there are cases such as inflammatory breast cancer or really involved cancers where we just, it's not physically possible to do a lumpectomy. Fortunately, Suzie didn't follow into any of those categories.

Andrew Schorr:

I was reading a study where it said a certain percentage of women, even if they're candidates for lumpectomy want to have mastectomy, want to have a more aggressive surgery because they are not convinced in their own heart that a lumpectomy is as good. What do the clinical studies show?

Dr. Calhoun:

The clinical studies show that there is a difference between lumpectomy with radiation and mastectomy in terms of the risk of a local or in-breast recurrence, but there has never been a study, which has shown a survival difference between the two. And so we do declare and we do feel that lumpectomy plus radiation and mastectomy are in fact equivalent in terms of treatment for the patient who is a candidate for both.

A local recurrence is a little bit higher with lumpectomy and radiation. We typically quote between 5 and 10 percent risk, but there are a lot of women who hear that and they say, well, I'm just going to do a mastectomy because this thing could never come back if I do that, which is actually not a true statement. There is the so-called chest wall recurrence that happens 1 to 2 percent. Some studies indicate as high as 5 percent. So even if you chose a mastectomy it doesn't completely eradicate a potential for a recurrence. And so difference, slight difference in terms of local recurrence rates, no difference in terms of survival, so we do feel that they are equivalent treatment options.

Andrew Schorr:

All right. We've got a lot more questions for you and more perspective from Suzie Hagerland when we continue our Seattle Cancer Care Alliance sponsored Patient Power program right after this.

Andrew Schorr:

Welcome back to Patient Power. I'm Andrew Schorr, as we're discussing surgical options for breast cancer. With us is Suzie Hagerland, 46 years old, mother of a young, three-and-a-half-year-old, Cassidy, who has just finished her first cycle of 24 cycles of chemotherapy for breast cancer after having first one surgery, a lumpectomy, and then a little wider surgery to make sure they got it all as best they could. And also with us is her doctor, a member of a multidisciplinary team. That's breast surgeon Kristine Calhoun from the Seattle Cancer Care Alliance.

Well, let's continue our discussion. Dr. Calhoun was describing the data about lumpectomy versus mastectomy and also about who are candidates for it. Dr. Calhoun, so mastectomy. So if you have mastectomy is that the end of it then? You don't need anything further? Or how does that work?

Dr. Calhoun:

So really it is all decided by the final surgical pathology, and it for the majority of patients will eliminate the need for radiation. However, even after a mastectomy there is a certain select patient population who have slightly more aggressive cancers. They are larger cancers, they have lymph nodes that are involved, or their margins, which are critical even after a mastectomy, may be involved or close, so those patients can still require radiation.

And the whole question of chemotherapy is actually not impacted by what type of surgery that you have. It really is based on the size of the cancers, the makeup of your cancer and whether or not it's in lymph nodes. And so those things are not impacted by the lumpectomy choice or the mastectomy choice. So it's actually quite common patients will come in and say, well, I'm going to pick a mastectomy because I don't want to do chemotherapy. And our education of the patients is, well, no, it really won't have an impact on that because we're going to take it on face value, the chemotherapy recommendation.

Andrew Schorr:

Dr. Calhoun, so in Suzie's case it was determined based on the actual biology of her tumor that it would be needed to have chemotherapy. Is that how it works?

Dr. Calhoun:

Correct. So she's a young woman, and she had a couple of lymph nodes where the cancer was involving those lymph nodes from the axilla, and so those were really the overriding reasons why her medical oncologist, who was one of her treatment team members involved in that initial discussion, opted after surgery to recommend chemotherapy.

Andrew Schorr:

Let's talk about lymph nodes for a minute. Some women have lymph nodes that are clear, other women don't. Some have many lymph nodes removed, some don't. How do you determine that?

When Should Lymph nodes be Removed?

Dr. Calhoun:

In Suzie's situation we actually knew going into her surgery that at least one of the lymph nodes had evidence that the breast cancer had spread to it, and that's because after that initial MRI one of the lymph nodes looked different. So our radiology department was able to use an ultrasound, saw that the lymph node still looked abnormal, did a needle biopsy very similar to the biopsy she had for the breast lesion and that determined that that lymph node was in fact involved with her cancer. And so going into the surgery we knew that with the lumpectomy I was also going to perform a lymph node dissection.

Sometimes we're getting that information actually during the actual surgery. For patients who are going into surgery and we don't know what the lymph node status is, they don't have anything that feels suspicious or looks suspicious on any of the mammograms or the ultrasounds or the MRIs, we actually perform what's called a sentinel lymph node biopsy. And the sentinel node is the first lymph node that is getting drainage from the breast that has the cancer in it, and so you basically map out that lymph node by using some radioactivity and some blue color dye. You remove it, and then you determine whether or not that lymph node has cancer, and if it does, then the patient needs what Suzie ended up having, which is the lymph node dissection.

Andrew Schorr:

Years ago it used to be that a lot of things were determined in the OR while the woman was asleep. Did she have breast cancer or not,

Dr. Calhoun:

Right.

Andrew Schorr:

...and would she have her breast removed or not. And now it seems you're making determinations maybe not on that but about the lymph node surgery. How does a woman emotionally prepare for that?

Dr. Calhoun:

I think that we have really come a long way. Our radiology colleagues are so fantastic at doing needle biopsies for us that we know going into the surgery whether or not, for the majority of people whether or not a lump is actually cancerous or not. So it's allowed us to actually eliminate a lot of surgical procedures where the patient has absolutely no idea what they're going to be told.

For the lymph nodes we can actually analyze them in the operating room, because sentinel node we don't have an idea until it's taken out. So we can actually do the lymph node analysis there in the operating room, and if the patient is in agreement if the lymph node does turn out to be positive in the operating room, then we can actually do the lymph node dissection. That, basically the patient has to accept some unknown going into the operation. They're going to go to sleep not knowing how many lymph nodes we're ultimately going to be taking out and whether or not they're going to wake up with one of these drains in place.

Andrew Schorr:

Suzie, how did you prepare for this? We haven't really talked about the emotional side of it, but I mean you were on what for many would be a real emotional roller coaster, and now you've got weeks ahead of you of chemotherapy, and we wish you all the best. But how have you navigated this?

Suzie:

Well, I think, um, as, reluctant may be not quite the right word, but as much as I wanted to get into surgery quickly, and Dr. Calhoun did a really good job of talking me through why the MRI and additional tests were necessary before surgery, once I had the results knowing that my lymph node was involved in the cancer, I was very glad that I went into the surgery knowing that as opposed to coming out of the surgery with the question mark. So it helped, one, that Dr. Calhoun took the time to explain it to me and really help me understand why it's so critical as part of the full treatment. And then the surgery you know, it is what it is, but it's such a critical piece of the whole treatment, and I was so focused on, partially due to my daughter, partially due to my husband, partially just due to me, you know, I want to be here and I want to get through this and I want to come out of the other end healthier than I went into it.

Andrew Schorr:

Right. Right. Dr. Calhoun, let's talk a little bit about reconstruction. So being a man, I don't quite understand this, it's not me, but breasts are important to a woman, and so when you start cutting on them or maybe a woman is going to lose one at some point she's probably going to discuss with you what are my options for reconstruction. Help us understand that and when that can happen.

Options for Reconstructive Surgery

Dr. Calhoun:

So for a lumpectomy we, actually all of us at the Seattle Cancer Care Alliance, we practice what's called oncoplastic surgery as long as the patients are appropriate candidates, and Suzie actually was, where we really take strides when we're doing the lumpectomy to somewhat reposition the tissues so that we achieve as natural of a contour and shape to the breast as possible. Because doing reconstruction to a breast which has had a lumpectomy as well as radiation can be very challenging. It's basically not really offered except for very rare circumstances. And if the surgeon has done the lumpectomy appropriately they shouldn't actually need it, any reconstruction after a lumpectomy with radiation.

The mastectomy patients are different. Their breast has entirely been removed, and we have four fantastic plastic surgeons that I work with quite closely, and as long as the patient is felt to be a good reconstruction candidate we absolutely bless them to go and meet with them. Reconstruction is something where it's not a simple procedure. It's normally a process. It involves multiple, normally two to three operations. There are different types in which it can be done. I'd say the most common is we place an expander, which is kind of a temporary spacer, that then gets the chest wall ready for an implant. And then there are some tissue reconstructions where the plastic surgeons actually move the abdominal, some of the abdominal wall or some of the inner thigh or some of the gluteus or some of the back muscle to reconstruct the breast.

Those are definitely multidisciplinary decisions and the patient's overall treatment does have some bearing on how much of this reconstructive process we'll let the patient initiate at the time of their mastectomy.

Andrew Schorr:

Yeah, that was my question, is how do you determine if there can be immediate reconstruction, so where the plastic surgeon, you step back and the plastic surgeon steps up during the same operation?

Dr. Calhoun:

Exactly. And that's, we do probably about 45, 50 percent of our reconstructions are in fact immediate reconstructions, and that really has to be based on what sort of treatment will this patient need afterwards. We typically will allow them to at least start the process even in the face of chemotherapy. We'll get the mastectomy done, the plastic surgeons will do the first step of the reconstruction, and then they'll get their chemotherapy.

It really becomes tricky if radiation is going to be required, and immediate reconstruction and radiation are somewhat at odds. But what we typically do is the radiation oncologist is part of that initial multidisciplinary planning session, and if they say, you know, I think this patient probably is going to require postmastectomy radiation, we'll either tell the patient you need to do delayed reconstruction or we'll do sort of a temporizing measure. We'll still do a more of a

skin-sparing approach for the mastectomy, and then we'll put in one of those spacers. That spacer can stay in there indefinitely, and the patient can have their needed cancer treatments, and then once that's all said and done then we release them back. It can be a number of months even to a year, year and a half afterwards to then do their reconstruction.

It really is a team decision, and it's not just the surgeon, it's not just the plastic surgeon. It's all of the components deciding together.

Andrew Schorr:

Now, different women will have different views as to what is sort of cosmetically acceptable to them. So that's a discussion you have too, isn't it?

Dr. Calhoun:

Yes.

Andrew Schorr:

Where do they want to end up.

Dr. Calhoun:

It's so individual. Some people feel that the absolute worst thing that could happen to them is a mastectomy, and so they will ask us to at times even do what we term a heroic lumpectomy. And they are willing to have a breast which is smaller, maybe slightly different in size and shape, than the other breast but they still have their breast. And for some patients that's really important.

Some patients it's not as important for them in terms of preserving the breast, and they are more willing to do a reconstruction. It's somewhat beauty is in the eye of the beholder. My goal is to leave the person with a breast or a reconstruction which looks as natural and as much like what they started with as possible, and then we just go from there.

Andrew Schorr:

All right. I have really one more question sort of at the end other end of the scale. So for the woman who is terrified by all this and wants maybe aggressive surgery, she may say, you know, my biggest fear, as successful as you can be in cutting out this cancer, is that I could develop cancer in the other breast. Should we consider you removing that too, now? I imagine that has come up.

Breast Removal as the Only Option

Dr. Calhoun:

That is a question which actually is becoming more and more prevalent. There's been literature on it, and in the last five years it's really, I don't want to say gained in popularity, but it's definitely something that we're confronting more and more. The patient who has a breast cancer on one side does have a slightly increased risk

to their other breast, but it's not a guarantee. So they will erroneously sometimes come in and say, I want to survive this so I want you to take both of my breasts off.

Well, back to the very beginning, doing a mastectomy over a lumpectomy doesn't improve your survival and so removing a normal breast definitely would not improve your survival. It's a normal reaction. Women are very frightened when they're handed this completely life-altering diagnosis, but if you talk to the patient really the only reason to remove a healthy breast and do a prophylactic mastectomy is if you have a very, very high risk of having something develop five, ten, twenty years from now in that breast. I don't have a crystal ball to say who is going to develop that and who is not. It's an option and I never would tell a patient no as long as their thought process was reasonable, but it's not something that ever has to be done.

I normally tell patients there's one patient and one patient alone who I tell they need bilateral mastectomies, and that's the patient who has bilateral breast cancers where they can't be treated with lumpectomies. Everyone else, it's an option, but it's not something I would ever force them to do.

Andrew Schorr:

Suzie, I imagine with your own journey and what you're hearing today women should realize how individualized this is, shouldn't they?

Suzie:

Absolutely, and how important it is to have a team that you do feel comfortable with. One of the things that really helps solidify the decision to move forward with the team that we met with at the Seattle Cancer Care Alliance was the fact that my husband and I are both pretty inquisitive. We do a lot of research online, which has pros and cons to it, but Dr. Calhoun and the rest of the team didn't shy away from the fact that we were asking very specific questions about if you're saying my increased chance of X is 2 percent tell me specifically which 2 percent and what's driving that. They took the time. They showed us some data. They didn't shy away from us asking those detailed questions, and that's what made me particularly feel comfortable.

Andrew Schorr:

So, Dr. Calhoun, we've discussed a lot of options, and Suzie and her husband had a lot of questions for you. How do you feel about questions? Because there's an emotional overlay. It's overwhelming for so many families touched by this, and then Suzie got that call, as she said, as other women who are listening today maybe have gotten it as well, and then you start talking about options. So they have questions. Are there stupid questions, or do you welcome them all?

Dr. Calhoun:

There is no such thing as a stupid question. And really I can explain and I can tell someone what the options are, but I've done my job if they understand why these options are available to them. In some patients it takes questions, others it

doesn't. I actually like questions because then that means that the patient and their family members are processing what we're telling them, and it is more of a dialogue, and so I definitely welcome them. And sometimes it takes a couple of visits in order to get all those questions answered.

There's a lot of talking that goes along with cancer treatment, and I am more than willing to spend as much time with the patients as they need. Some patients need a little bit more, sometimes patients need a little bit less. Again, that's very individualized, but if they can understand why, then I've done my job.

Andrew Schorr:

And as far as surgical options, years ago, it wasn't all that long ago, sentinel node biopsy was developed, and are there new things that you feel are improving surgical oncology for breast cancer?

Dr. Calhoun:

I think it's always an evolving field, and we're really now trying to address, does a patient who has a positive sentinel node always need a lymph node dissection. And then are there better ways in which we can target who will benefit from this. And the research that's going along with imaging for the breast to make sure we can more completely screen so that we really find those patients who are the absolute best lumpectomy candidates. I think it's an ever-evolving field. We're refining our lumpectomy techniques so that even with larger lumpectomies patients will hopefully still be happy with the breast that they're left. The radiation oncologists are really focusing more on the concept of more limited radiation. And so it is an exciting field.

Andrew Schorr:

Well, we wish you all the best with what you do. And, Suzie, she seems like a great doctor to have, a wonderful communicator.

Suzie:

Well, I can't complain. It's actually been wonderful for me, and I've bugged her with several e-mails, and she's been so patient about answering every one of my e-mails and keeping humor and being gentle at the same time. So right now I'm just, I'm as happy as can be.

Andrew Schorr:

Well, we wish you all the best. Having been chemotherapy, it's not, you know, a walk in the park, but hopefully you have many, many years of a long life together and dance at that kid's wedding, right?

Dr. Calhoun:

That's our entire treatment team's goal for her.

Andrew Schorr:

There you go. We'll all dance at Cassidy's wedding. Okay. Well, thank you so much for being with us, Dr. Kristine Calhoun, breast surgeon at the Seattle Cancer



Care Alliance, and also her patient, Suzie Hagerland who is going through chemotherapy now after going through breast surgery with Dr. Calhoun, but it sounds like, Suzie, you have a great team and a lot of confidence going forward. Thank you, Suzie. All the best to you. Dr. Calhoun, thank you for being with us.

Dr. Calhoun:

Thank you.

Suzie:

You're welcome.

Andrew Schorr:

Well, this is what we do on Patient Power on so many programs sponsored by the Seattle Cancer Care Alliance. So hopefully this answers many of your questions about surgical options for breast cancer, but obviously it's an individual discussion with you and your doctor. And if you need a second opinion, want a second opinion, as you've heard from Dr. Calhoun, she welcomes giving them and having her patients get them and you need to feel confident in what's right for you.

I'm Andrew Schorr. Remember, knowledge can be the best medicine of all.

Please remember the opinions expressed on Patient Power are not necessarily the views of Seattle Cancer Care Alliance, its medical staff or Patient Power. Our discussions are not a substitute for seeking medical advice or care from your own doctor. That's how you'll get care that's most appropriate for you.