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Best personal regards,
Dr. Silvana Martino

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Breast Cancer Advisor

BY DR. SILVANA MARTINO • March 2012

BIOLOGY BASICS

The topic I wish to discuss in this issue is how oncologists oversee their patients during therapy and once therapy has been completed. These guidelines apply to patients who have early breast cancer and not metastatic disease when different guidelines are necessary.

During the period of active treatment, the schedule of visits, labs, x-rays and scans are determined by the therapy that is given, and by the need for evaluation and treatment of any side effects that a person might experience. There is also variation based on your own doctor and their habits. Some oncologists like to personally see their patients often. Others are accustomed to entrusting more of the care to their nursing staff.

Once the acute phase of therapy is completed, we then set up a long term monitoring schedule. Each of your physicians will arrange their own schedule with you. Your surgeon will likely see you every six months for the first 2-3 years and then go to a yearly schedule. Some surgeons will relegate following you to the medical oncologist. I do not favor this. I prefer a surgeon

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Biology Basics continued

who follows you directly. The radiation oncologist will also want to see you periodically. Generally this will also be every six months for the first several years and then yearly.

The medical oncologist is the physician who will follow you most closely. There are no set rules as to how often they see and examine you, but a common pattern is to see you every three months for the first two to three years and then go to a six month schedule until five years have elapsed from the time of diagnosis. Thereafter, you can expect to be followed yearly. For those on long term hormonal therapy, most of us like

to see our patients at six month intervals until that therapy is completed, before we progress to a yearly visit.

The purpose of follow-up examinations is to look for signs of tumor recurrence. This is done through physical exams, labs, and mammograms. Other types of x-rays and scans are not generally done on a routine basis. They are done if there are reasons to suspect that there is possible evidence of tumor recurrence or some other medical issue. The reason why x-rays and scans other than mammography are not done on a regular basis is because recent studies have demonstrated that their routine use in patients without symptoms has not resulted in an improved survival. It does result in increased radiation exposure which one wants to avoid.

For each of you, it is important that you are clear from each of your physicians as to how they plan to follow you and how often you are to be examined. Also, please be sure you are clear about which of your physicians will order and review your mammograms.

Many patients ask if they still need to see all of their other non-oncology doctors. The answer is yes. Your family doctor, your gynecologist and any other physician that you had before the cancer diagnosis still need to continue your care, and be informed about your oncology care.



BIOGRAPHY

Dr. Silvana Martino

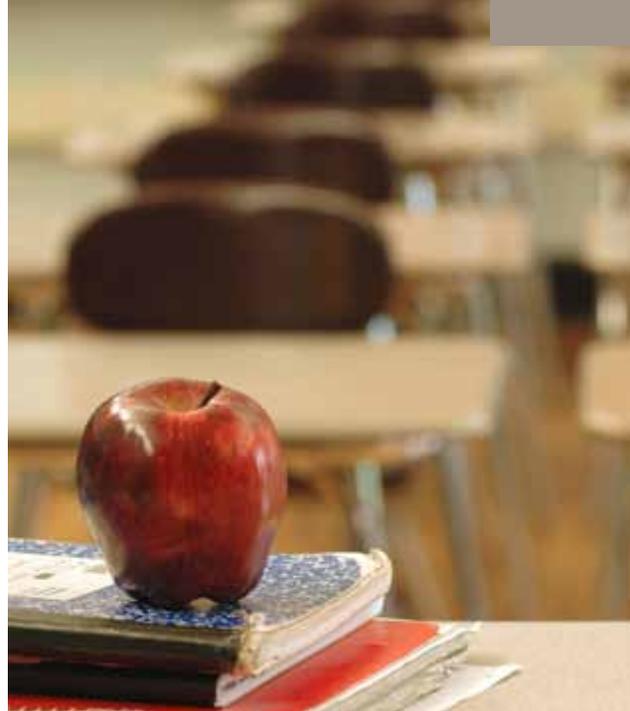
is the Director of Breast Cancer Research and Education at The Angeles Clinic Foundation. She is board certified in internal medicine and medical oncology. Dr. Martino has specialized in the treatment and research of breast cancer for over three decades. She is a nationally recognized leader in the field of breast cancer. Her body of work has included research in breast cancer prevention, treatments for early breast cancer and metastatic disease. Dr. Martino has conducted and coordinated large national and international studies which have resulted in changing the standard of care worldwide.

**DR. MARTINO'S
CURRICULUM VITAE**

REMEMBERING A GREAT TEACHER

Allow me to share an experience with you, and to make a point. I was recently asked to contribute some personal material for a book. In that process, I was reminded of the many great teachers that I have had during my years of education and training. A few stand out above the others. One of them was Dr. Larry Jacobson, a neurologist who was also in charge of our clinical training when I was in medical school. He was logical and rigorous in his teaching. I learned neurology well. However, it is not for this that I remember him most; it was for other reasons. One is that he loved his students. His pride in us was obvious. The second reason was for a statement that he drilled into us: “Your job is to add life to years and not years to life”. As a young student this did not completely make sense to me as I felt that, above all, my job as a physician would be to prolong life. Nevertheless, since he stressed this so much, and it was contradictory to my expectations, the statement stayed with me. Only as I became an oncologist and matured did I appreciate the wisdom of his words.

The third reason is that he rendered a critical service to me personally. He always backed me up when I was faced with teachers who did not wish to teach me since I was a woman. In such circumstances, I would simply leave and make other arrangements. This left Dr. Jacobson



to deal with the school's administration. I caused him considerable headaches, but he always understood and allowed me to achieve my educational goals.

I have not seen Dr. Jacobson since I graduated in 1973, yet I have always felt that I owed him a great debt in shaping me. Many times over the years I have thought that I should contact him and tell him how important he was to me in my formative years. Yet, I did not do so.

As I was recently searching the internet to obtain the proper spelling of his name, I found a notice that he had died two weeks previously. I missed the opportunity to tell a great teacher how much his lessons meant to me. I wrote a small note to his family, but it was not the same.

So, what is my point? It is to remind all of us to do what we consider important today, and not put things off.

WHAT'S NEW

Management of Positive Sentinel Lymph Nodes

How one deals with the lymph nodes located in the axilla (the arm pit area) in the management of breast cancer is a very important question. The original surgical treatment was to remove most of these lymph nodes (an axillary dissection). This procedure removes many but not all lymph nodes from the axilla. The reasons for this surgery were (1) to remove nodes that contained tumor, (2) to predict probable recurrence of the tumor and overall prognosis, and (3) as a way of guiding us about the need for drug therapy. This surgical approach was logical, but caused considerable debility. Surgeons have been very aware of these problems and have done important research to figure out whether an axillary dissection was really necessary, or whether we could achieve the same treatment goals in other ways. The most recent data suggest that at least in some circumstances, much less lymph node surgery is needed. This is the topic addressed by our guest writer this month.

GUEST WRITER

ALICE CHUNG, MD, FACS

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There have been recent changes in the recommendations for the surgical treatment of the lymph nodes under the arm (axilla) for patients with early stage breast cancer. Axillary surgery has been a focus of great concern among patients with breast cancer. Removal of most of these lymph nodes is called an axillary dissection. This procedure has been found to result in limited range of motion, numbness, pain, and lymphedema (swelling) of the affected arm. All of these symptoms can negatively impact the quality of

life for many of those requiring this operation.

In the early 1990s, Dr. Armando Giuliano and his colleagues at the John Wayne Cancer Institute in Santa Monica, California, developed the “sentinel lymph node biopsy”; a less invasive procedure that allowed patients with early stage breast cancer to undergo a surgical biopsy of one or two axillary lymph nodes without having to remove all of the lymph nodes in the axilla (1). The sentinel lymph node is the first lymph node that drains the breast. If cancer is not identified in this first node, then cancer has probably not spread to the other axillary lymph nodes and patients can

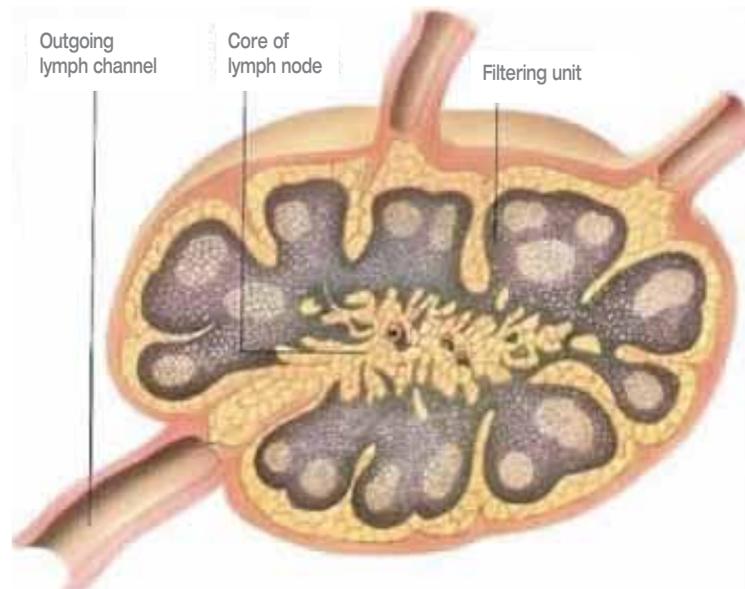
If cancer is not identified in this first node, then cancer has probably not spread to the other axillary lymph nodes and patients can be safely spared the axillary dissection.

be safely spared the axillary dissection. Until recently, the standard of care for those patients found to have cancer in the sentinel lymph node has been axillary dissection to ensure that any residual cancer in the axilla is removed. For those in whom the sentinel node biopsy was negative, no further nodal surgery is done.

New research, pioneered by the American College of Surgeons Oncology Group, led by Dr. Giuliano, has demonstrated that even certain patients with cancer identified in the sentinel lymph node may not require the axillary dissection and can be safely spared the side effects of this aggressive operation (2, 3).

This recent study included 891 patients with early stage breast cancer who had lumpectomy with cancer identified in the sentinel lymph node biopsy; 445 patients were randomly assigned (like the flip of a coin) to have axillary dissection and 446 were randomly assigned to have no further axillary surgery. All patients had radiation therapy after the operation. The large majority of women also received either hormonal therapy and/or chemotherapy. Most had 1 to 3 nodes involved. The patients were followed to determine if one group did better than the other. At 5 years, survival

DIAGRAM OF A LYMPH NODE



continued next page

Guest Writer continued

rates were found to be equivalent between the 2 groups. These findings indicate that patients who have cancer identified in the sentinel lymph node will have the same survival rate whether or not all the lymph nodes under the arm are removed. As the survival rates are similar regardless of which operation (sentinel node biopsy or axillary dissection) is performed, there is no benefit to removal of all of the lymph nodes in patients with cancer identified in the sentinel lymph nodes. These patients can, therefore, be spared axillary dissection. This research study has changed the standard surgical management of the lymph nodes and has had a huge impact on the breast cancer community. The quality of life for many patients may be improved as a result of this study.

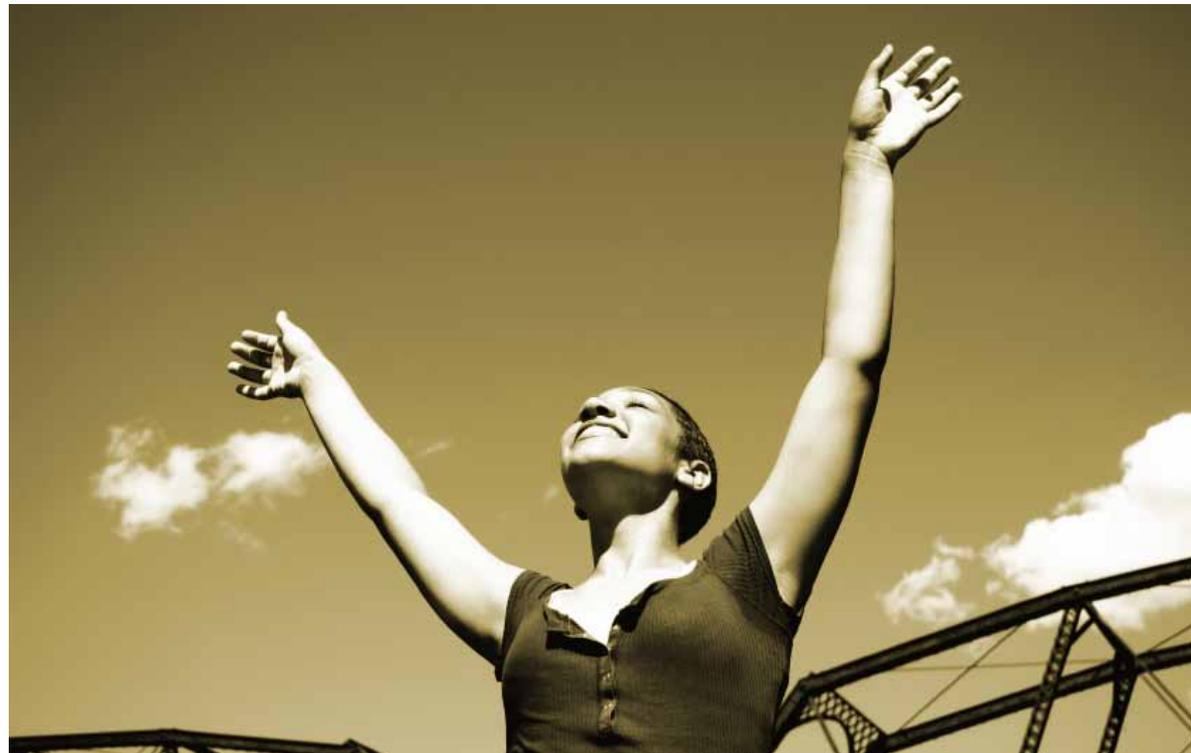
It is important to note that this research study does not apply to all breast cancer patients. As a general guideline, women with Stage I or II breast cancer, who are undergoing lumpectomy and sentinel lymph node biopsy, followed by standard whole breast radiation and also receive either chemotherapy and/or hormonal therapy, may be considered appropriate candidates for this surgical approach, as long as they do not have

This research study ... has had a huge impact on the breast cancer community. The quality of life for many patients may be improved as a result of this study.

more than 3 sentinel lymph nodes that contain cancer. Axillary dissection remains the standard of care for those with cancer in the sentinel node if they will be treated with mastectomy, will have lumpectomy without whole breast radiation, have more than 3 sentinel nodes involved, or have more advanced breast cancer than Stage I or II. It is important for patients undergoing surgical treatment to discuss with their surgeon whether they are a suitable candidate for this approach.

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1. Giuliano AE, Kirgan DM, Guenther JM, Morton DL. Lymphatic mapping and sentinel lymphadenectomy for breast cancer. *Ann Surg.* 1994 Sep;220(3):391-8; discussion 8-401.
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3. Giuliano AE, McCall L, Beitsch P, Whitworth PW, Blumencranz P, Leitch AM, Saha S, Hunt KK, Morrow M, Ballman K. Locoregional recurrence after sentinel lymph node dissection with or without axillary dissection in patients with sentinel lymph node metastases: the American College of Surgeons Oncology Group Z0011 randomized trial. *Ann Surg.* 2010 Sep; 252(3):426-32; discussion 432-3.



QUESTIONS & ANSWERS

(Q) Dr. Martino, I am confused about who my oncologist is. My radiation doctor says he is my oncologist, and my chemotherapy doctor says he is my oncologist. Who is it?

(A) Actually, they are both correct. The word oncologist is appropriately applied to a physician who has special training in treating cancer. If your surgeon has special training in doing cancer surgeries, than that person is a surgical oncologist. The doctor who did your radiation is a radiation oncologist. The doctor who has given you the drugs for cancer is your medical oncologist. Generally speaking, when the general public uses the expression “oncologist”, they are usually referring to the medical oncologist. There are also nurses who have special training in treating cancer patients. They are known as oncology nurses.

E-mail your questions to:
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Upcoming Foundation Events

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Melanoma Education Symposium

March 24, 2012 • 8:00 AM - 12:00 PM
Four Points Sheraton
Los Angeles, CA

Breast Cancer Seminar

April 22, 2012 • 3:00 - 5:00 PM
Smith College Club of Los Angeles
Studio City, CA

Breast Cancer Seminar

May 3, 2012 • 7:00 - 9:00 PM
Temple Beth Hillel
Valley Village, CA

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