Re: Time to Adjuvant Chemotherapy for Breast Cancer in National Comprehensive Cancer Network Institutions

We read with great interest the paper by Vandergrift et al. (1) in the January issue of the Journal. The authors demonstrated that among the factors affecting the initiation of adjuvant treatment, second and third excisions cause a 2.1- and 5.7-week delay, respectively, in the time to chemotherapy as compared with single excision. We provide additional data suggesting that re-excision must be tempered in the early postoperative period in women who have undergone breast-conserving surgery (BCS) with affected margins and who are candidates for systemic treatment.

Among 2801 patients with BCS treated in the last decade at the Vall d’Hebron University Hospital of Barcelona, Spain, 85 underwent re-excision for affected margins. Re-excision was immediate, done at the same surgical time as BCS in 7 (8.2%) patients, or deferred to a subsequent surgical time in 78 patients (91.8%). Median time from BCS to deferred re-excision was 4.0 weeks (range = 1.86–32.43 weeks). Patients with deferred re-excision received delayed adjuvant systemic treatment as compared with patients who underwent immediate re-excision (9 weeks vs 6.9 weeks; P = .02). Furthermore, deferred re-excision was statistically significantly associated with commencing adjuvant treatment more than 8 weeks after BCS (P = .009). Indeed, a total of 53 patients (68%) and 10 patients (12.8%) with deferred re-excision started adjuvant systemic therapy more than 8 weeks and 12 weeks after initial BCS, respectively. These findings indicate that patients with re-excision for affected margins received treatment with a delay similar to that reported for second excision by Vandergrift et al. (1).

Regrettably, there is no consensus on treatment of patients with affected margins after BCS. A possible strategy to avoid delayed systemic treatment is to postpone re-excision to the conclusion of chemotherapy. This option is reasonable because the status of margins per se does not affect the choice of systemic therapy. Another possibility is to select patients who really need re-excision. Recently, data have been reported on the use of a margin index to identify properly those patients with positive margins who deserve additional surgery (2).

Because treatment of patients with affected margins after BCS is unlikely to be the subject of a prospective evaluation, we kindly ask Vandergrift et al. (1) to provide additional information, particularly on pathological futures, of patients who have undergone second and third excision and to report the variability in re-excision rates among different institutions and surgeons, which has been recently debated in the oncology community (3).

It is our opinion that collaborative efforts are required to facilitate a tailored approach to scheduling second excision and chemotherapy and to optimize the delivery of systemic treatment.

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References

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We agree with the comments from Di Cosimo and colleagues regarding the importance of both limiting the number of patients who require multiple excisional procedures and minimizing the delay in subsequent therapy among patients who require additional surgery to achieve clear margins. However, we are examining these topics as part of another study that is currently underway and are not yet prepared to publish these data.

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