

[MUSIC PLAYING]

SARAH So when we think about the treatment of breast cancer, we think about it from a comprehensive strategy of the
MCLAUGHLIN: breast, of what could be going on anywhere else, and then how do we create a treatment plan that addresses all of those issues? We have a large number of really targeted therapies which minimize the damage to good cells, if you will. They target the bad cells. And then in addition to that, we're really able, in a comprehensive strategy, to be able to say, OK, if we do this surgery and we take out the tumor, and we take out one or two lymph nodes, then we can actually treat the rest of the body.

We have data in women that compare breast conservation to mastectomy with 30-year follow up demonstrating clearly that there's no difference in survival if you have a lumpectomy and radiation or if you have a mastectomy. We are one of the few places across the country that does our breast surgery cases under a regional anesthetic. And you can be very precise, targeting only the nerves that affect the area of the breast and the lymph nodes where we're working. That allows us, then, to do the procedure where you're not awake, you don't remember, and you don't feel anything, but you're still breathing on your own. And there is an increasing body of data that suggests by doing a regional anesthetic approach, where you really localize the anesthetic or the numbing medicine to the place where we're working, that may actually decrease the stress response of the body to the procedure, and that may have implications on future risks for recurrence.

There are some techniques that we can do to rearrange the tissue within the breast so that when you remove a portion of the breast, you're not left with a large "divot," for lack of a better word, within the breast. We're able to rearrange that tissue back into that location, maintain a more normal cosmetically acceptable breast-oncoplastic surgery. We also then take that to a next level, use that with the plastic surgeons, may do combined procedures with them, where we're able to reposition the nipple or do a reduction at the same time.

There's all kinds of new techniques related to nipple-sparing approaches, where we actually save the nipple and areolar complex, which can really be the hardest part for the plastic surgeon to reconstruct in the future, especially when they try to match symmetry to the other side. And so the opportunity to save your native nipple without increasing your risk of cancer recurrence is also a significant contribution. And then even beyond that, there are really advanced reconstruction techniques, where we use a patient's own tissue, that really, are becoming the gold standard of breast reconstruction because really, as you age, those may gain weight and lose weight naturally as your normal breast would, which, in the end, results in a better cosmetic outcome.

I think the future of breast cancer care, if I can start there, is getting more and more targeted. The more targeted we can get, the better. The better the outcomes are, the shorter the treatment duration, the fewer the side effects.

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