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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

A Global View of Challenges in Breast Cancer Care

Announcer:
Welcome to *Breaking Boundaries in Breast Cancer* on ReachMD, sponsored by Lilly.

Mr. Nacinovich:
Despite the fact that breast cancer is the most common cancer in women around the world, the ability to access comprehensive treatment for this disease still hinges largely on which country you come from. For women living in countries with low to medium economies, opportunities are few and far between. So, what can be done at the global health level to bring critically needed care to more breast cancer patients?

This is Breaking Boundaries in Breast Cancer on ReachMD. I'm Mario Nacinovich, and joining me is Dr. Ben Anderson, Professor of Surgery and Global Health Medicine at the University of Washington. Dr. Anderson is Director of the Breast Health Global Initiative, BHGI, at the Fred Hutchinson Cancer Research Center, and he is a consultant to NCCN and the World Health Organization for breast cancer-related activities.

Dr. Anderson, welcome to the program.

Dr. Anderson:
Thank you so much for having me. I'm pleased to be here.

Mr. Nacinovich:
So, just to set a baseline for us to start, can you share how the survival rates of breast cancer patients differ among countries?

Dr. Anderson:
Well, as you said, breast cancer is the most common cancer among women around the world, and globally it's the most likely reason that a woman will die of cancer. That's not true in the US—it's #2—and that's because we have made major progress in terms of the outcomes of breast cancer. Between 1990 and the present time, breast cancer mortality, age adjusted, has dropped by 35%, and so this demonstrates that there's great opportunity for improvement and has been achieved in high-income countries.

This improvement has not been mirrored in low- and middle-income countries where breast cancer mortality has been fixed or rising, and this is due to multiple factors, but it certainly creates this opportunity to address the major disparities that are apparent. If you think of breast cancer survival in the US, with our improvements in early detection as well as treatment, 90% or better live 5 years with the disease, and there's a significant fraction of patients that do not recur during their natural lifetime. If one looks at Sub-Saharan Africa, the situation is quite different, where the majority of patients die of their disease. So, one of the major questions that the Breast Health Global Initiative has been trying to address is: What is it that contributes to these differences, and how can we translate what we've learned from high-income countries into these resource-disparate regions?

Mr. Nacinovich:
And in your experience, what factors contribute to this global disparity?

Dr. Anderson:
Well, if you think about breast cancer, the ways in which we address this are driven by the biology of the disease, and there are 2 major factors that allow us to improve on outcome. First, we need to be able to treat the cancer effectively, and we've made major inroads in terms of the multimodality therapy of surgery, radiotherapy, and systemic therapy for improving breast cancer survival, but that's necessarily linked to early diagnosis, so we have to find the cancer at early enough stages that our therapies are effective. A problem in

underserved countries around the world is that a high fraction of women present with locally advanced or metastatic disease at initial presentation. One of the major disparities has to do with patients either presenting late or in some circumstances presenting not late but not being worked up in a timely fashion in those settings.

The Breast Health Global Initiative has developed guidelines called Resource-Stratified Guidelines, and they provide a framework for identifying the essential elements that make improvements in outcome, and they are based upon diagnosing the disease early, making an accurate diagnosis within a reasonable period of time—target less than 60 days—and then initiating multimodality therapy in a way that the patients get through their treatment to improve on these outcomes.

Mr. Nacinovich:
So, if we consider the whole continuum of care from risk assessments to diagnosis, to treatment, to long-term monitoring, where do you think the biggest disparities reside for breast cancer patients?

Dr. Anderson:
Well, I think part of the answer to that question is in recognizing that it's not a one-size-fits-all situation, and so, when you go to different areas, you may find that the problems are different depending on those environments. For example, in Sub-Saharan Africa, when these women are coming in with locally advanced tumors, you're already in a very difficult situation. We see the same picture in much of Latin America. This is a combination of the patients not having knowledge about disease and waiting until it's really problematic and hurts and that's the point in which they present, but it also has to do with the availability of resources that we consider fundamental. So, being able to do an ultrasound and a needle sampling of a palpable lump in the breast, we don't consider that to be a major limitation in our part of the world but is actually a huge issue in Latin America, in Sub-Saharan Africa and Southeast Asia, so thinking about how to make diagnoses is appropriate.

Therapy is also an issue, and while surgery and radiotherapy are critical for local regional control, access to medications is vital, and so having the drug therapies accessible and affordable is a big issue. The World Health Organization developed a list of essential medicines for cancer treatment, and having these cancer treatments available, affordable, and accessible is one of the major issues that WHO has been thinking through in advising the healthcare ministries.

Mr. Nacinovich:
And continuing on that track, what would you say are the most common barriers patients face in trying to access care in various parts of the world?

Dr. Anderson:
There's a universal problem that we see, not just in low and middle-income countries but also underserved communities in the United States, which is lack of insurance. These therapies are expensive, and so, if you don't have access to insurance and have to self-pay, that becomes an obstacle that we've documented over and over leads to poor outcome, and it's one of the reasons that patients who live in underserved communities in the US fail to get their therapy. When we think about drug therapy, it's really not the first dose of chemotherapy that matters. It's the last dose. Do the patients get all the way through their regimens? Because if you only go part way through your drug regimen and don't complete this, then you get the worst of all worlds. You get the side effects of the therapy without the evidence-based outcomes in improvement that we know work on the basis of high evidence, high-level prospective randomized trials, so understanding what allows patients to get through their treatment or what prevents them from getting through this is an important area that we often don't think about but really is fundamental and essential.

Mr. Nacinovich:
For those just tuning in, you're listening to Breaking Boundaries in Breast Cancer on ReachMD. I'm Mario Nacinovich and speaking with Dr. Ben Anderson, who's giving us an in-depth look into the global challenges to accessing comprehensive care for breast cancer patients.

So, Dr. Anderson, if we zero in on the diagnosis of breast cancer, what clinical strategies and/or public health policies can be implemented in lower or middle-income countries to tighten the diagnostic window?

Dr. Anderson:
Well, that's really an excellent question, Mario, and I have to say that some of our discussions and debates that we have in our setting in the US or in Western Europe have somewhat sent us off track. We've had huge debates about mammographic screening. What age do you start? Are we helping more people? Are we hurting people? And it tends to create the impression that mammographic screening is the fundamental intervention that's needed. That is fundamentally incorrect. Mammographic screening is very expensive, and if you think about the number of women you have to screen to find cancers, you might screen 1,000 women, have 100 that have an abnormality of which 10 end up being cancer, so that's a lot of investment to find those 10 cancers.

WHO realized if you're in a setting where women are presenting with cancers that are easily palpable or visible based upon ulceration, being able to get a picture of the breast is not the most fundamental issue. Actually, being able to make what's called early diagnosis—that means finding the masses when they are still small is a more cost-effective strategy because you're evaluating fewer women rather than the screened population, but you're also finding cancers that are definitely relevant, so this whole discussion of overdiagnosis and overtreatment really does not apply in settings where women are being diagnosed clinically. Furthermore, if you are not able to do diagnostic workups of palpable lumps, you certainly are not prepared to be able to do mammographic screening to evaluate lesions that you cannot see or feel and have to use special imaging techniques to find, so the availability of early diagnosis and the strategies for this are probably the most important element for the low and middle-income country environment.

There are 2 parts to that. One part has to do with patient awareness, but it also requires the healthcare system to be prepared to receive them. The initial diagnostic test is an ultrasound. Ultrasound is much more effective for looking at these palpable lesions. You have to remember that in these settings it's the very young women that are presenting, so women in their early 40s or even 30s where mammography has really been shown to have limited efficacy because of the density of the breast. So, being prepared to do ultrasounds, being prepared to do needle sampling is one of the most effective strategies, and you need to make them available.

Mr. Nacinovich:
What strategies have you personally found to be effective in addressing these care gaps when organizing or delivering care remotely?

Dr. Anderson:
It has to do with what are the drugs that we're selecting and what are the best ways of administering them. The move towards outpatient care makes things more practical. The use of less expensive medications is, of course, appropriate. WHO has been creating costing tools to help the ministries understand better what the implications are of the specific drug regimens that they pick, but I would say that equally important to this is having the diagnostic tests that tell you what drugs to give. If you don't have good pathology services, if you cannot distinguish an estrogen receptor-positive cancer from an estrogen receptor-negative cancer, then that really can send you off course in terms of what drugs that are recommended. So thinking through these strategies, not just about the drugs that are available but what is the distribution of my cancers and do I have the tests that can distinguish one from another, is really quite important and a fundamental strategy for making these improvements.

Mr. Nacinovich:
Lastly, Dr. Anderson, if we look ahead, what kinds of developments or advancements do you think could be on the horizon to improve overall survival rates and quality of life of breast cancer patients around the world?

Dr. Anderson:
Well, I do think we're making major advancements. We are able to make improvements, but they have to be stepwise and incremental. So, moving from a research perspective into implementation research, that is studying the implementation strategies to figure out what actually works in a limited-resource environment, this is really fundamental to making major improvements in outcome. And we have to recognize that one size doesn't fit all, that we need to be taking these strategies to the environment that it's appropriate for, and this is true in underserved communities in the US. If we go to areas where patients don't have good access to care and present with locally advanced or more advanced disease, actually they have outcomes that look very similar to a middle-income country even though they live in a high-income country, so I think we actually want to look at this from a global perspective, not just because we want to make global improvements but because these are the same strategies that we're going to be using in our own countries when we try to address our population as a whole.

Mr. Nacinovich:
Well, with those thoughts in mind, I want to thank my guest, Dr. Ben Anderson, for joining me to take a global health perspective on breast cancer. Dr. Anderson, it was great having you on the program.

Dr. Anderson:
The pleasure was mine.

Announcer:
You're listening to *Breaking Boundaries in Breast Cancer*, sponsored by Lilly. To revisit any part of this discussion and to access other episodes in this series, visit ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!