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Scientific Session Abstracts

Second Opinions, Same Standards: Time to Treatment for Breast Cancers Diagnosed Externally

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Background/Objective: The Commission on Cancer (CoC) advocates that therapeutic breast surgery in the non-neoadjuvant setting is performed within 60 days of diagnosis of stage I-III breast cancer. We hypothesize that patients who seek a second opinion (external) experience increased delays in time to first treatment (TTT) compared to those diagnosed within the same institution (internal) due to the need for additional workup and care coordination. This study compares TTT between external and internal patients with newly diagnosed breast cancer.

Methods: This retrospective cohort study involved patients with new stage 0-III breast cancer diagnosed externally and internally and treated at a single comprehensive cancer center between January and July 2024. Sample size and power were based on historical institutional TTT data with a total of 226 patients (113 in each group) ensuring a power of 80% with a two-sided type I error rate of 5%. Patients with metastatic disease, externally treated, or declining standard of care were excluded. Data collected included patient demographics, date of multidisciplinary consultations, number of additional imaging tests and biopsies obtained following initial visit, and treatment information. Two different times to treatment were calculated: time from biopsy to first treatment (TBT) and time from first surgical oncology clinic appointment at our institution to first treatment (TCT).

Results: The median age of our cohort was 59.8 years. Racial distribution was majority White (81.0%) and Black (13.3%). Of external patients, 38.1% were from a different state. Clinical tumor stages were T0 (0.4%), Tis (15.2%), T1 (54.5%), T2 (22.8%), T3 (5.8%), and T4 (0.9%). Clinical nodal stages were N0 (87.9%), N1 (11.2%), N2 (0.4%), and N3 (0.4%). Median TBT was 35 days (IQR=12, 29) with statistically significant difference between external (41.5 days) and internal (31 days) patients ($p< 0.00001$). Median TCT was 21 days (IQR=12, 29) with no statistical difference between external (20 days) and internal (21 days) patients ($p=0.6594$). Radiologists recommended additional workup more often for external (68.1%) than internal (25.7%) patients ($p< 0.001$), but surgeons recommended additional workup with similar frequency in each group (external 61.1%, internal 63.7%, $p=0.68$). External patients required additional imaging and biopsies more frequently (90.3%) than internal patients (68.1%), which was statistically significant ($p< 0.0001$). Excluding MRI, external patients still required additional workup more frequently (79.7%) than internal patients (54.0%, $p< 0.0001$). The need for additional workup correlated with increased median TCT (11 vs 22

days, p< 0.00001). The need for a plastic surgery consultation also correlated with increased median TCT (18 vs 26 days, p< 0.00001).

Conclusions: Obtaining a second opinion after external diagnosis increased the overall time from diagnosis to treatment but remained well within the CoC standard. There was no difference in TCT between internally diagnosed and externally diagnosed patients once they initiated care within our hospital system, even though external patients required additional imaging and biopsies more frequently. Patients should not be discouraged from obtaining a second opinion based on concerns about time to treatment, and systems efforts should be made to address barriers patients face when pursuing second opinions at comprehensive cancer centers.

Figure 1. Time to Treatment

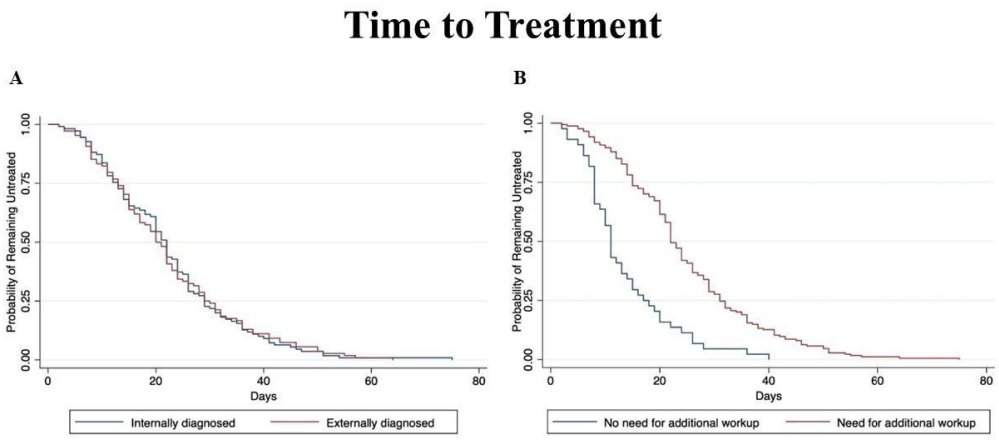

Figure 1. Time from initial clinic visit to treatment for (A) internally vs. externally diagnosed patients and (B) patients not needing additional workup vs. patients needing additional workup.