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Don't Avoid Second Opinions for Fear of Delaying Care

New Study Shows Second Consult and Treatment at Comprehensive Cancer Center Meets CoC Guidelines for Timely Treatment

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

Las Vegas, NV, May 1, 2025—Concerns about delaying treatment should not deter most patients with breast cancer from seeking a second opinion on diagnosis and treatment, suggests a new study presented this week at the American Society of Breast Surgeons Annual Meeting.

Researchers examined the time between initial biopsy and initiation of therapy for patients diagnosed and treated at the Cleveland Clinic (internal) and patients who received their diagnosis and initial workup elsewhere before coming to the Cleveland Clinic for a second opinion and treatment (external).

The study was led by Pooja Varman, MD, General Surgery Resident and Surgical Education Research Fellow and Zahraa Al-Hilli, MD, MBA of the Cleveland Clinic.

"For both cohorts, time from biopsy to first treatment fell well within the Commission on Cancer (CoC) guidelines," says Dr. Varman. "Not surprisingly, Cleveland Clinic internal patients had an even shorter time to treatment, but external patients' average time to treatment was still well within guidelines."

"Breast cancer is a life-altering experience. For patients, exploring all treatment options and finding a physician and clinical team they are comfortable with is crucial," she says. "But of course, timeliness is critical in cancer care."

Dr. Varman notes that this is one of the first studies that examines the relationship between second opinions and time to treatment comparing internal and external patients at a single comprehensive cancer center.

“Patients should be reassured that if they explore care options immediately after diagnosis, a short delay because of a second opinion is not detrimental to care,” she says.

“While institutional differences in timing certainly may occur,” Dr. Varman adds, “it is likely that other comprehensive cancer centers have measures in place to expedite and deliver care within a timeframe similar to our institution. Patients may inquire in advance about how long the second opinion process actually takes.”

The retrospective study focused on newly diagnosed patients with DCIS and stage I to III breast cancers between January and July 2024. They did not receive chemotherapy or other therapies prior to the second opinion. Patients with metastatic disease or who declined the standard of care were excluded. The mean age of the cohort was 59.8 years. Of the external patients, 38.1% came from outside of Ohio.

Internal and external patients began treatment at a mean of 35 and 41 days post-diagnosis respectively. CoC guidelines call for treatment initiation for patients not receiving pre-surgical therapies at 60 days. In addition to the time elapsed between consults, treatment delays between internal and external patients were also attributable to the need for additional imaging exams and biopsies for the second opinion as well as pre-surgical consults with plastic surgeons, if required.

“Patients seek out second opinions for a wide variety of reasons,” says Dr. Varman. “Cancer treatment is a physically and emotionally difficult journey and feeling comfortable with the path chosen is extremely important. This study should reassure patients that a second opinion need not impact all-important timeliness of care.”

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

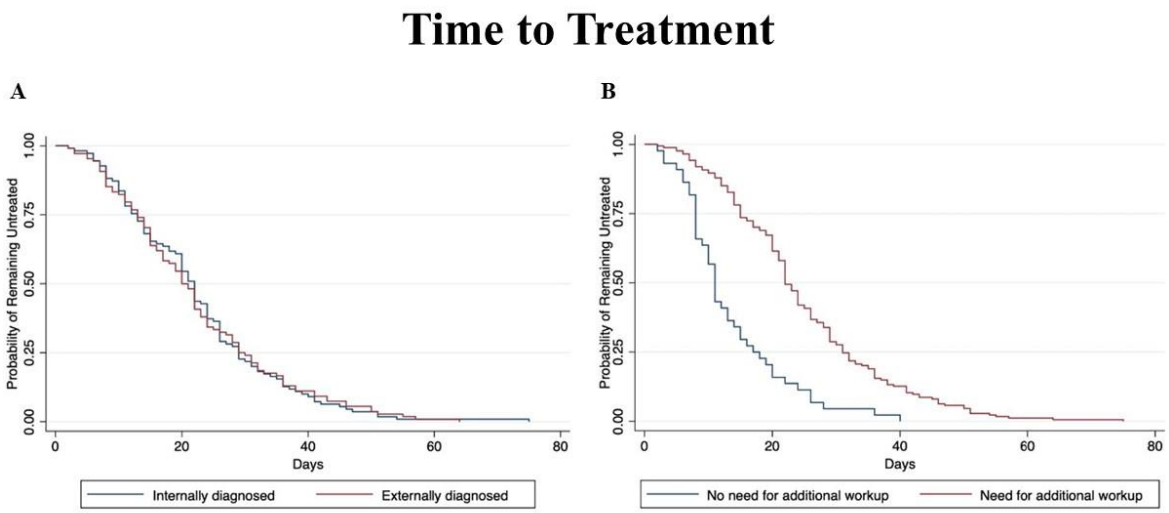

Figure 1. Time from initial clinic visit to treatment for (A) internally vs. externally diagnosed patients and (B) patients not needing additional workup vs. patients needing additional workup.