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EDITORIAL

Symptomatic breast services in the post-COVID-19 era

The COVID-19 pandemic has necessitated unprecedented changes to the functioning of hospitals across the world. This article evaluates the acute impact of COVID-19 on the provision of symptomatic breast services in the UK and explores suggestions for more sustainable functioning of services in the post-COVID-19 era.

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Introduction

The COVID-19 pandemic has necessitated unprecedented changes to the functioning of hospitals across the world. Radiology departments have had to evolve in a dynamic manner to the changing demands of imaging and balance this demand with patient safety. COVID-19 has brought a renewed focus on the running of symptomatic breast services and ‘one-stop’ symptomatic breast clinics.

There are currently 5–7 million NHS patients waiting to be seen by specialists (Campbell, 2020), which will include patients with as yet undetected breast cancers. The COVID-19 pandemic has highlighted the immense resilience of NHS staff, and has led to important and rapid changes implemented by breast centres across the UK to reduce footfall and face-to-face contact. The authors give some suggestions to modify symptomatic breast services going forward. These are the authors’ opinions and come from their experiences of working during the first wave of the pandemic and responses to a small survey sent to breast radiologists in the UK.

Teleconsultations

The authors hope that crowded waiting areas and overbooked breast clinics will be a thing of the past. A more robust system of triaging (Pediconi et al, 2020a) by clinicians via video link or telephone could be implemented to ensure that patients with urgent problems are seen first, before seeing patients with symptoms such as breast pain. Similarly, follow-up appointments to discuss benign results could be performed virtually.

Modification of one-stop clinics

Running separate clinics for vulnerable patients who are at high risk from COVID-19 could reduce their exposure to potential infection. Patients could be given an option to attend ‘imaging-led’ breast clinics, from which patients can be discharged back to the community if imaging is normal. In this way, patients get to see a surgeon only if a biopsy is performed or for any other concern. Most patients attending one-stop breast clinics are ‘worried well’ patients who do not need to see the surgeon. This would drastically reduce exposure of patients to COVID-19 by reducing the number of contacts between patients and staff and reducing footfall in the department (Bansal, 2019). This is already in practice in 19% of respondents’ sites, as found by a recent survey sent to all active members of the British Society of Breast Radiologists, which received 160 responses (Bansal, 2020). However, this would require radiological and surgical buy-in and a combined team effort from both radiologists and surgeons.

Changing practice

Although the frequency of performing certain procedures like Vacuum-assisted biopsies and excisions were reduced during the pandemic, its rates are creeping up again. Other procedures like clip placements have increased in frequency during and after the pandemic

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(Doughty, 2020; Pediconi et al, 2020b). For example, uncertainty regarding the availability of operating time in some centres meant that tissue clip markers were inserted into all cancers, before 'holding' treatment with neoadjuvant systemic therapy for oestrogen receptor-positive tumours or HER2 enriched tumours until such time as operating space became available (Doughty, 2020; Pediconi et al, 2020b).

Based on the insights gained from responses to the authors' survey (Bansal, 2020), the frequency with which certain procedures are performed could be reduced. These include biopsy of probable fibroadenoma in patients <30 years of age if rigorous criteria for 'no biopsy' are met (Maxwell and Pearson, 2010), and perhaps biopsies in indeterminate mammographic (M3) microcalcifications, following consensus by two clinical staff members. Patients should be involved even more than before in shared decision making by using virtual platforms to allow discussion of the various options. Unnecessary clinical appointments could be avoided if investigations and procedures adding no value to patient management could be filtered out. These changes would need to be agreed at a local level and robustly audited.

Modification of multidisciplinary team meetings

Following the Paterson inquiry (Department of Health and Social Care, 2020), there has been a push towards longer multidisciplinary team meetings. In the pre-COVID era, it had become a norm to discuss all routine and standard cases in a multidisciplinary team meeting. Sometimes these discussions are used by clinicians to provide a degree of protection, as the decision shifts from an individual to a team decision, and provides peer review and support. The authors believe that only complex cases should be discussed in a multidisciplinary team meeting. Shorter and fully or partially virtual multidisciplinary team meetings are already taking place and could continue in the post COVID-19 era with fewer discussions of cases involving benign biopsies or routine surveillance (Bansal, 2020).

Replacement of wire-guided procedures

Replacement of wire localisations with alternatives such as radiofrequency identification and Magseed techniques is likely to free up radiological time (Micha et al, 2021). These can be used at a time that suits the breast imaging department. Wire-guided surgery has limitations including that it has to be performed on the day of surgery, along with issues such as wire displacement, trauma to patients, intraoperative wire transections and retention of wire fragments. Non-wire localisations improve surgical options for better cosmetic options, as the radiologist's access approach is independent of the surgical approach. Decoupling of radiology and surgery schedules leads to flexibility. This would be particularly relevant in the creation of 'COVID free' zones in the hospital, and would also reduce patient and staff stress on the day of the procedure.

Maintaining staff morale and safety

Staff morale is crucial in these challenging times. To allay staff and patient anxiety, provision of proper personal protective equipment, regular and scheduled staff virus testing and organised monitoring of patients for temperature and symptoms will be necessary. Wearing masks in clinic will have an impact on communication with patients. Communication is likely to take longer than usual, so extra time should be allowed for each appointment. More frequent structured psychological support could be provided by teleconsultations, when possible (Pediconi et al, 2020a).

In this period of recovery and restoration, the backlog of demand for imaging needs to be balanced with safety of both patients and staff. Symptomatic breast centres function in a range of different settings. As long as patients are screened for symptoms with regular temperature checks, most patients attending the breast centre are 'low risk'. However, the time between seeing patients has to be increased to allow for frequent cleaning of imaging equipment and 'high-touch areas'. This would increase patient and staff confidence. To increase capacity, extended working hours including weekend working and flexible working patterns could be explored, but would have to be agreed at the local level.

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Key points

- In the post-COVID-19 era, one-stop breast clinics will need modification to reduce footfall.
- Increasing reliance on virtual follow-up clinics, imaging-led clinics and virtual triaging of referrals would reduce contact between patients and staff.
- Multidisciplinary team meetings could be run in a fully or partially virtual manner with reduced discussion of patients with benign biopsies or routine surveillance scans.
- Wire-guided procedures could be replaced by other procedures, like Magseeds, which provide more flexibility in scheduling patients for surgery.
- To reduce patient and staff stress, regular testing of staff and screening for symptoms of all women attending breast clinics is warranted.

Conclusions

COVID-19 has brought in some rapidly implemented changes in symptomatic breast cancer services. In future, these changes could lead to a renewed focus on shared decision making with patients and added value to the care provided to patients.

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