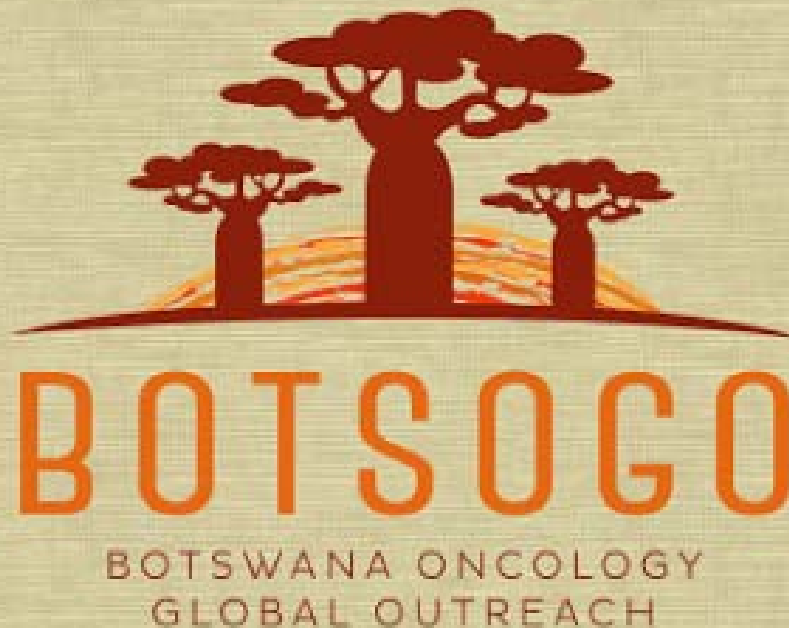


A 32 year-old pregnant female with right
breast lump

Bokang Rabasha
Isaac Nkele



Continuing Medical Education Announcement

Harvard Medical School

RSS 3081: Monthly BOTSOGO Tumor Board; 2018-2019 Academic Year

Today's Objectives:

- Describe the need for timely cancer case presentation and referral to treatment
- Formulate a multi-disciplinary plan for the care of common and complex oncologic cases
- Adopt successful, sustainable strategies to mitigate barriers to quality cancer care common in resource constrained environments

Target Audience:

Oncologists, internists, surgeons, radiation oncologists, infectious disease specialists, nurses, physicists, therapists, technicians, research staff, administrators, policy makers.



Financial Relationships

The following planners, speakers, and content reviewers, on behalf of themselves and their spouse or partner, have reported financial relationships with an entity producing, marketing, re-selling, or distributing health care goods or services (relevant to the content of the activity) consumed by, or used on, patients:

Name	Role	Type of Financial Relationship

All other individuals including course directors, planners, reviewers, faculty, staff, etc., who are in a position to control the content of this educational activity have reported no financial relationships related to the content of this activity



Statements

Accreditation Statement

The Harvard Medical School is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians

Credit Designation Statement

The Harvard Medical School designates this live activity for a maximum of 1 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity

This activity meets the criteria of the Massachusetts Board of Registration in Medicine for 1.0 credits of Risk Management Study

Disclosure Statement

In accord with the disclosure policy of the Medical School as well as standards set forth by the Accreditation Council for Continuing Medical Education, course planners, speakers, and content reviewers have been asked to disclose any relevant relationship they, or their spouse or partner, have to companies producing, marketing, re-selling or distributing health care goods or services consumed by, or used on, patients.



Claim your CME credits!

- To claim your CME credit for attendance at this session of the BOTSOGO Tumor Board, please fill out our survey after the Tumor Board.
- You can do this at your convenience on your personal or work computer by navigating to www.botsogo.org
 - Click “What We Do”
 - Click “Tumor Board”
 - Click the link under the section “Continuing Education Credits,” and complete and submit the survey
- Or follow the link that was emailed to our MGH BOTSOGO email list: www.tinyurl.com/tumorboard



Core Principles of Case Review

Clinicians, pathologists, and other other members of the health care team uniformly strive to provide the best possible clinical care.

Despite these efforts, adverse outcomes still occur

Reflection on and re-evaluation of our practices and outcomes are imperative to continuously improve the care to provide to patients



Core Principles of Case Review

Discussion will focus on medical decision-making and reporting systems

Discussion is privileged and content should not be discussed outside of this forum.

We seek to create a safe, collaborative, open and respectful atmosphere for discussion, learning, and improvement



CASE: 35yoF HIV- with right breast lump

"History of right breast lump in pregnancy"

Enrolled in Potlako at SLH/OPD in early 2019
post-diagnosis with triple negative (Her2 1+ by
IHC) infiltrating moderately differentiated ductal
cancer



Clinical History/Timeline

8 years prior: Right breast lump noted during pregnancy with first child (did it disappear?)

4 years prior: Presented to clinic with bilateral breast lumps and swelling under left armpit.
Tentative Dx: Lipoma

3 years prior: Mammogram completed but report not available for several months



Clinical History/Timeline

2 years prior

- Mammogram report described fibrocystic mass “with or without malignant changes.”
- Booked surgical clinic for query of cancer at district hospital
- FNA and excisional biopsy advised at different clinic
- FNAC interpreted as consistent with abscess.
- Persistent mass, booked for surgical clinic



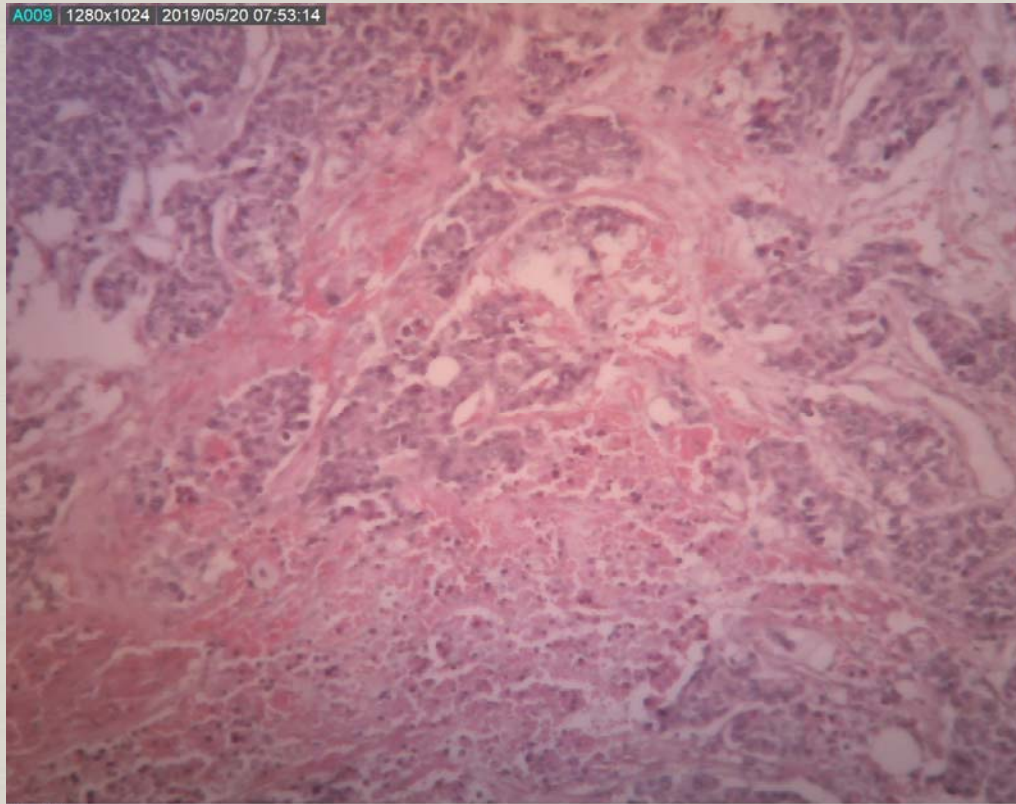
Clinical History/Timeline

2 years prior

- Excision of right breast lump performed.
- Post-op visit 4wks later, pathology report not available, patient provided contact details to clinic
- Prelim pathology report signed out ~8wks post-surgery, final report signed out ~16wks
- **Pathology report showing infiltrating ductal carcinoma, ER-, PR-, HER2-**



Pathology: 1 of 8

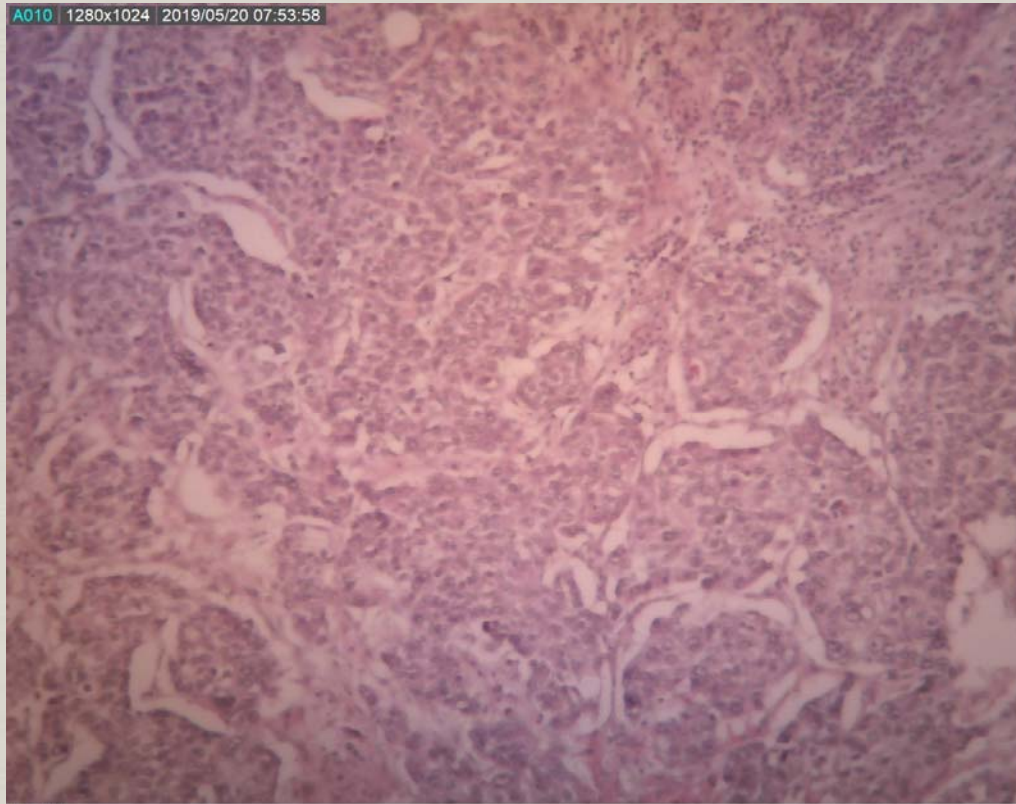


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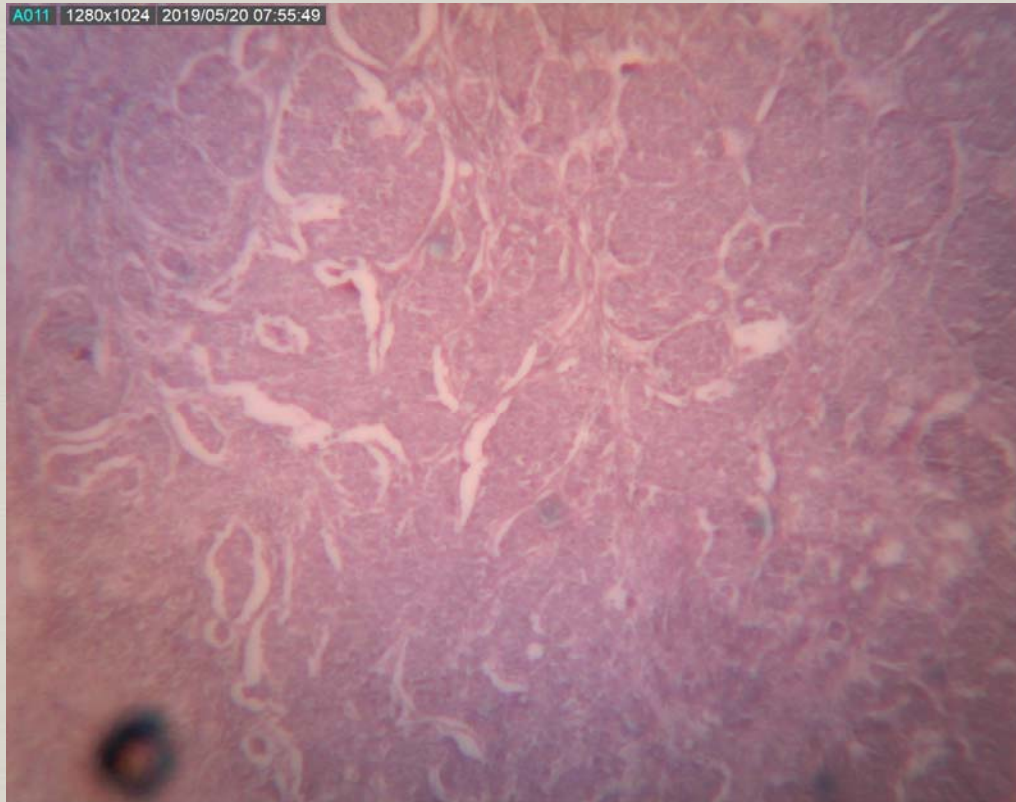
Pathology: 2 of 8



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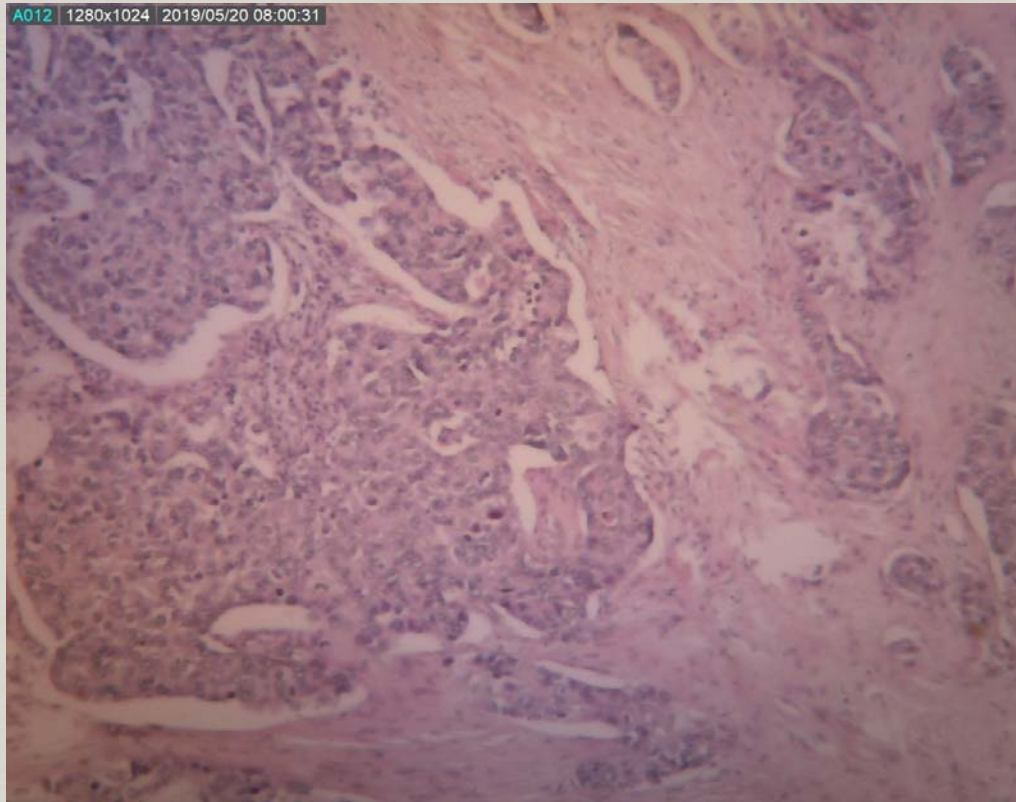
Pathology: 3 of 8



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Pathology: 4 of 8

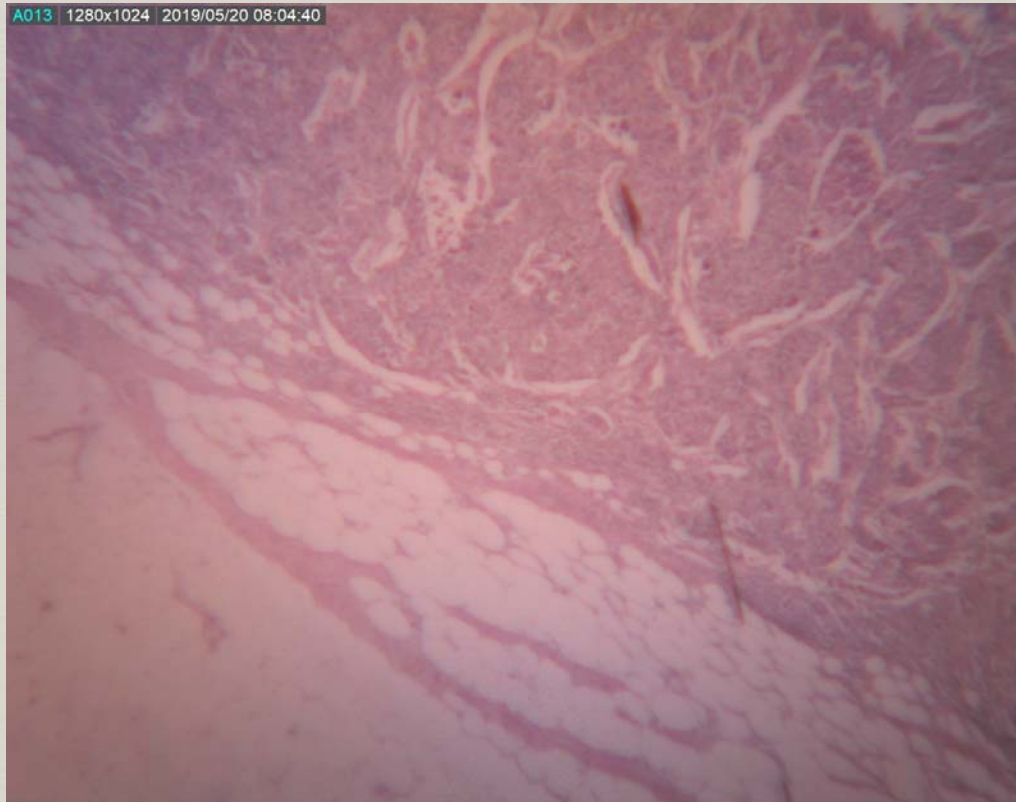


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Pathology: 5 of 8

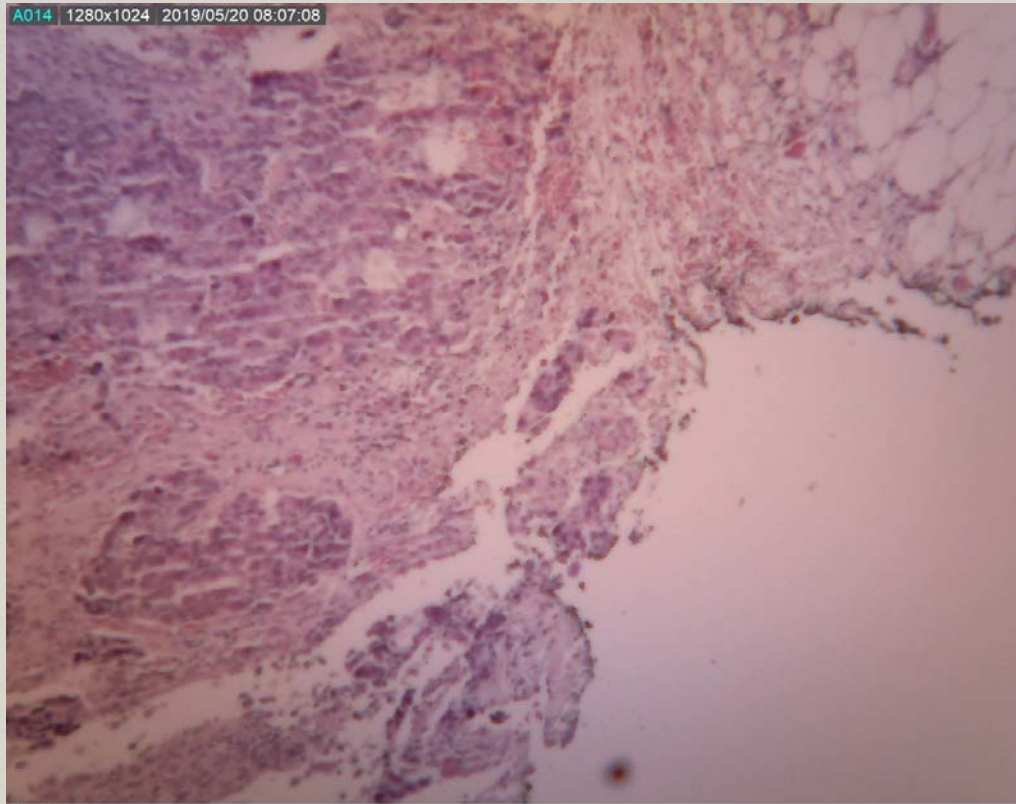


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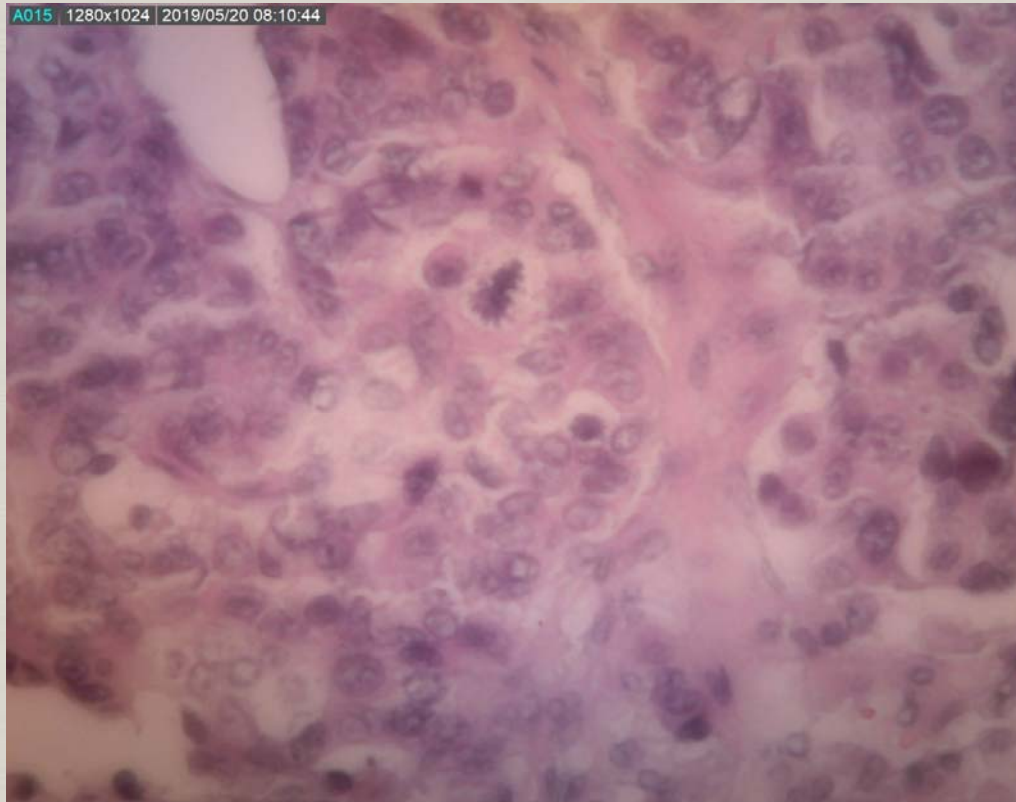
Pathology: 6 of 8



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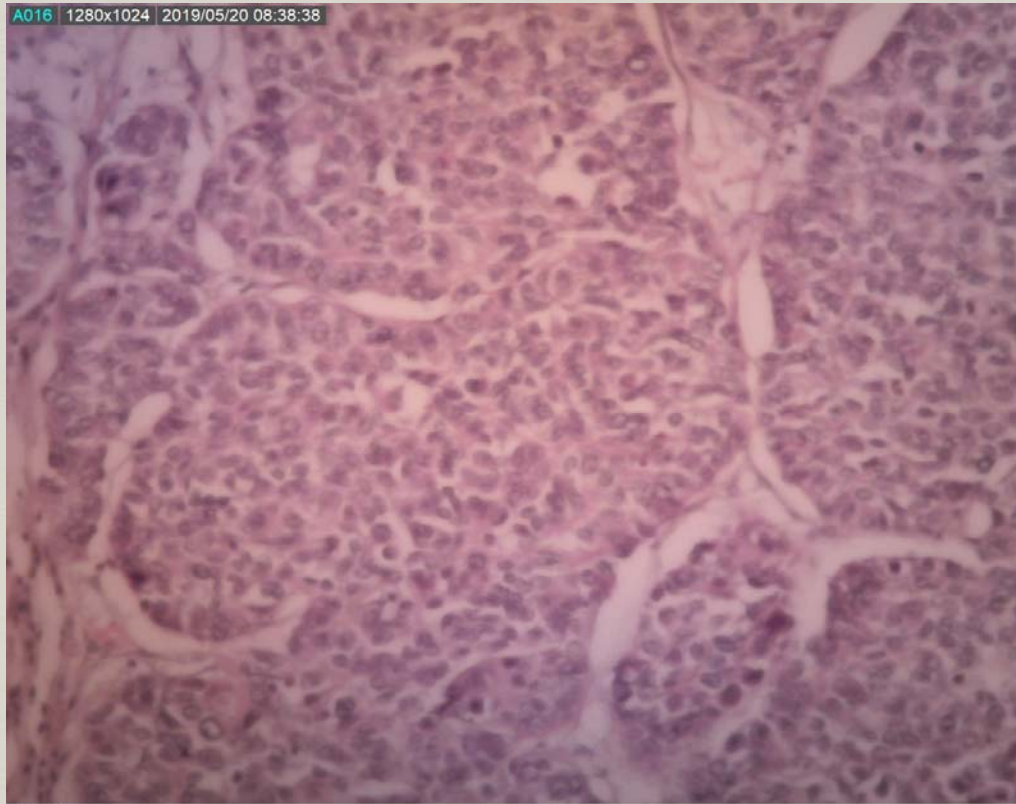
Pathology: 7 of 8



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Pathology: 8 of 8



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Pathology report,

Gross: A nodular firm fibrofatty tissue measuring 5.5x4.9x3.9cm. Surgically inked. C/S showed solid white mass with foci of hemorrhagic areas.

Diagnosis:

BREAST; RIGHT; LUMP; EXCISIONAL BIOPSY

- Infiltrating ductal carcinoma
- **Grade 2** (Tubule - 3, Pleomorphism - 2, Mitotic figure - 2. Total score - 7.)
- Tumor size 5.5 * 4.9 * 3.9 cm
- Tumor involves surgical margins
- No definitive lymphovascular invasion noted
- Background shows pregnancy changes.



Clinical History/Timeline

7 months prior

- Local clinic visit for breast lump, referred to surgery
- Re-presented to district hospital, exam with 10cm R breast lump with ?breast hyperplasia
- Booked for resection 4mo later, given NSAIDS
- No evidence sought prior path report in IPMS
- Breast U/S showed hypoechoic mass, Axillary masses, Enlarged lymph nodes in axillary region. Dilated right mammary ducts at the nipple region



Clinical History/Timeline

2.5 months prior

- Presents as scheduled for lump excision
- Admitted to district hospital
- Discharged 2d later, could not do surgery as operating theatre contaminated
- Rebooked for surgery 2mo later
- No record that anyone looked for report of prior resection



Clinical History/Timeline

0.5 months prior

- Surgery rebooked for 2mo in future



Clinical History/Timeline

Index visit

- Self-refers to different district hospital where initial resection was performed 2yrs prior
- Pathology report retrieved
- Patient counselled that has cancer, enrolled in Potlako to facilitate care
- CXR, FBC, U/S, RFT/LFTs performed



Clinical History/Timeline

2 weeks later

- Seen in PMH oncology clinic
- Exam notable for peau d'orange skin, multiple palpable lymph nodes (largest is 2x3cm). Lump of 16x13cm hard fixed to skin
- CXR and U/S without apparent mets
- Punch tenderness, T8-10
- Referred for MRI at GPH, pending



Key questions

- What is the typical pathway for cancer diagnosis in Botswana?
- What are the pitfalls in the system?
- Where are the opportunities for intervention?



Challenges in reporting pathology results

Adapted from Silverman et. al

- 1) Physician that does procedure e.g. biopsy, is not part of patient's care beyond that point
- 2) Referral procedures based on preliminary results and tentative diagnosis
- 3) Patient lost to follow-up due to a location move post-procedure
- 4) Diagnosis communicated to person who doesn't pass on the message to relevant clinicians
- 5) Primary method of communicating results to the clinician treating the patient is ineffective

