The Breast Health Center at Good Samaritan Hospital Medical Center:
Building on a Rich History of Comprehensive, Community-based Care
NEARLY 25 YEARS AGO, GOOD SAMARITAN HOSPITAL MEDICAL CENTER ESTABLISHED THE BREAST HEALTH CENTER (BHC) IN RESPONSE TO CONCERNS ABOUT THE INCREASING INCIDENCE OF BREAST CANCER AMONG AREA RESIDENTS. THE BHC HAS SINCE EVOLVED INTO A LONG ISLAND DESTINATION FOR NATIONALLY ACCREDITED, UNIVERSITY-LEVEL SCREENING, DIAGNOSTIC AND THERAPEUTIC SERVICES IN A COMMUNITY SETTING.

ESTABLISHED IN 1993, the BHC has received three consecutive three-year accreditations from the National Accreditation Program for Breast Centers (NAPBC), with the most recent in 2015. NAPBC accreditation is a testament, in part, to the BHC’s outcomes: Survival rates by cancer stage meet or exceed national averages, as do reoperation rates. The comprehensiveness of the BHC’s services — which include advanced imaging and biopsy techniques, leading-edge breast surgery and reconstruction, radiation, chemotherapy, hormonal therapy, genetic counseling, and support services — allows patients to remain close to home for the same high-level care they could find in the city.

A PIONEERING WOMEN’S IMAGING CENTER
Most patients enter the BHC’s system of care through Good Samaritan’s spa-like Women’s Imaging Center (WIC). Anne Green, MD, a breast imaging specialist and the WIC Director, leads a staff of dedicated breast radiologists and mammography- and ultrasound-accredited technologists who performed approximately 30,000 imaging studies last year. The WIC is an American College of Radiology (ACR)-accredited Breast Imaging Center of Excellence and holds
Meet the Breast Health Center Clinicians

**JOHN FRANCFORT, MD, FACS,** has practiced as a breast surgeon at Good Samaritan since 1988. He is Chair of the Department of Surgery and a past president of the Good Samaritan Medical Board and the Brooklyn–Long Island Chapter of the American College of Surgeons. Dr. Francfort received his medical degree from the University of Medicine & Dentistry of New Jersey before completing a residency in general surgery at the Hospital of the University of Pennsylvania.

Breast surgeon *Anthony Capizzi,* MD, FACS, a graduate of New York Medical College, has been a member of the medical staff at Good Samaritan Hospital Medical Center for nearly 30 years. He joined as a surgery attending in 1988 after completing a surgical internship and a surgical residency at Montefiore Medical Center. Dr. Capizzi has held several leadership positions at Good Samaritan, including president of the medical board.

Radiation oncologist *Johnny Kao,* MD, is a graduate of the Mount Sinai School of Medicine. After an internship at Beth Israel Medical Center in New York, he completed a residency at the University of Chicago. Prior to joining Good Samaritan in 2012, Dr. Kao was assistant professor in the Department of Radiation Oncology and director of clinical research at the Multidisciplinary Head and Neck Cancer Center at Mount Sinai School of Medicine in New York and director of the Tampa Bay Cancer Center in Brandon, Florida.

Providing exceptional skill, experience and compassion, Chair of Surgery John W. Francfort, MD, performs a high volume of breast surgeries at Good Samaritan Hospital Medical Center, fostering excellent outcomes for his patients and receiving accolades from them.

ACR accreditation in mammography, stereotactic breast biopsy, breast MRI and breast ultrasound. The WIC’s services include:

- 2- and 3-D screening and diagnostic mammography
- Conventional and 3-D stereotactic-guided breast biopsy
- Breast MRI
- High-resolution breast ultrasound
- MRI-guided breast biopsy
- Surgical localization
- Ultrasound-guided breast biopsy

“The WIC has always been on the cutting edge of technology,” Dr. Green says. “Years ago, we participated in an early trial of digital mammography. Our hospital was one of the first on Long Island to receive ACR accreditation for breast MRI, which many women newly diagnosed with breast cancer undergo prior to surgery to evaluate for extent of disease in the affected breast and to detect otherwise occult cancers in the contralateral breast. We also use breast MRI as a screening tool for high-risk patients.”

In recent years, the WIC was the first center in Suffolk County and the second on Long Island to perform 3-D mammography, a modality that is beneficial for all patients, regardless of breast density, according to Dr. Green.

“It’s important to find most cancers before they are symptomatic, with a palpable lump,” Dr. Green says. “Cancers found during screening exams are more likely to be smaller and confined to the breast, and studies have shown that cancers found with screening need less aggressive treatment and are more likely to be cured. That is why we are excited to offer 3-D mammography. Early studies have indicated 3-D mammograms find more invasive cancers and result in fewer false positives and callbacks than 2-D mammograms.”
Coordination with patients’ primary care physicians is a hallmark of the WIC. “Whenever biopsy results indicate a diagnosis of atypia or cancer, we notify the referring clinician immediately,” Dr. Green says. “He or she is welcome to share the results with the patient, or we will, depending on his or her preference.”

The WIC prioritizes patient convenience and comfort. It offers screening and diagnostic appointments Monday through Saturday with early morning and evening hours to accommodate busy schedules. This year, the WIC became the first imaging center on Long Island to introduce a prone 3-D breast biopsy table, which allows patients to lie comfortably during tissue sample extraction instead of having to sit or stand.

THE POWER OF MANY VOICES
A radiologist from the WIC is one of many members of the breast health team that meets every Friday morning for a multidisciplinary conference to discuss newly diagnosed patients’ cases before they undergo surgery. Bradley Cohen, MD, breast surgeon and Chair of the Breast Leadership Committee at Good Samaritan, calls the conference “the center of what we’re doing” at the BHC.

“Breast cancer treatment used to consist mainly of surgery, followed by radiation therapy or chemotherapy in a few cases,” Dr. Cohen says. “Now, most patients undergo a combination of therapies, and deciding who should receive which treatments and in what order is a complex process that requires all of the relevant subspecialists to get together in one room and review each case.”

Most such reviews start with the breast surgeon presenting the patient’s clinical history, followed by presentations of the imaging studies by the radiologist and biopsy results and diagnostic conclusions by the pathologist. Conference participants also include medical oncologists, radiation oncologists, plastic/reconstructive surgeons, geneticists, gynecologists/primary care physicians and nurse navigators. Together they form a treatment plan, with three key figures — the breast surgeon, the radiation oncologist and the medical oncologist — taking the lead.

“Surgically, patients have either a lumpectomy or mastectomy, depending on their needs and preferences,” Dr. Cohen says. “After surgery, whole- or partial-breast irradiation may be indicated to prevent recurrence. We now have excellent techniques that allow us to reduce the number of sessions needed.”

“Systemic therapy may also be useful,” Dr. Cohen continues. “Hormonal therapy, which blocks cancer cells’ estrogen stimulation, is often quite effective and easy to tolerate. We reserve chemotherapy for..."
patients with more aggressive cancers with a higher risk of recurrence. Part of the medical oncologist’s role is to determine not only who may benefit from chemotherapy, but ensure those who receive it can tolerate it, as well.”

Neoadjuvant therapy may be appropriate for certain patients, such as those with large tumors or aggressive disease, according to Dr. Cohen. In such cases, he says, chemotherapy delivered before surgery may shrink a tumor to the extent that a lumpectomy becomes appropriate instead of a mastectomy.

**AT THE FOREFRONT OF BREAST SURGERY AND RECONSTRUCTION**

Dr. Cohen — a graduate of Yale University and Mount Sinai School of Medicine — began offering breast care on Long Island nearly 30 years ago, following a surgical internship and residency at Lenox Hill Hospital in Manhattan and a surgical oncology fellowship at Memorial Sloan Kettering Cancer Center. He has been affiliated with the BHC since it opened. During his career, he has seen lumpectomy become a viable alternative to mastectomy for many patients. The trend toward less and less radical procedures continues, Dr. Cohen says.

“We now have excellent techniques that allow us to preserve the breast without compromising cancer care,” Dr. Cohen says. “Even for patients who are having mastectomy, we have ways of sparing the nipple and areola. Another excellent example of how we’ve gradually been able to perform less invasive procedures on breast cancer patients is sentinel node biopsy. This allows us to identify and test the first nodes cancer is likely to spread to, and if they are clear, have a high level of certainty that the rest will be clear, as well.”

“The ability to avoid removing all of the lymph nodes in the underarm area, as was once standard, helps prevent complications, such as lymphedema,” Dr. Cohen continues. “Some new studies suggest that even if a small amount of cancer exists in the lymph nodes, we can still safely avoid an axillary dissection.”

When patients — typically those undergoing mastectomy — desire breast reconstruction surgery, early coordination between the breast surgeon and plastic surgeon is key.

“If there is a concern that the cosmetic results from breast conservation therapy may be suboptimal, the breast surgeon and the plastic surgeon can discuss that beforehand, and the patient can have a consultation with the plastic surgeon to discuss reconstructive options after mastectomy,” says Stephen Harris, MD, Chief, Division of Plastic and Reconstructive Surgery at Good Samaritan. “It is also important for the plastic surgeon to know if a patient is going to receive post-mastectomy radiation therapy so the reconstruction can be performed in a way that provides the best outcome while accommodating the need for radiation.”

The plastic surgeon is present at the time of mastectomy to accomplish the first stage of reconstruction, which may involve placing a saline or silicone implant or transferring tissue from elsewhere in the body. In some cases, both mastectomy and the complete reconstruction using a silicone implant can take place during one procedure, an approach known as direct-to-implant reconstruction. Breast and plastic surgeons at Good Samaritan have refined this technique, according to Dr. Harris.

**Probing Genetics to Guide Screening and Prevention**

**BOARD-CERTIFIED GENETIC COUNSELORS** at Good Samaritan Hospital Medical Center inform clinical decision-making for high-risk individuals, such as those with a family history of breast cancer or relatives who carry the BRCA1 or BRCA2 gene mutations, as well as patients who are diagnosed with breast cancer prior to menopause.

Genetic counselors attend the Breast Health Center’s weekly conference to inform the multispecialty team about high-risk patients, which may prompt additional imaging or surgical screenings for those individuals. Genetic information helps clinicians determine whether prophylactic therapy, such as estrogen-blocking medication, is appropriate for women with an elevated risk for breast cancer.
The BHC has long been at the forefront of breast reconstruction surgery thanks, in part, to Dr. Harris, who trained with some of the field’s pioneers during his plastic surgery residency at Emory University in the 1990s. From there, he went on to complete a hand and microsurgery fellowship at Massachusetts General Hospital and Harvard Medical School. He began practicing at Good Samaritan in 2000.

“We offer the full range of breast reconstruction, including implant-based options and autologous techniques with microsurgery,” Dr. Harris says. “Some of the newest forms of implant reconstruction, including direct-to-implant and pre-pectoral implant reconstruction, are available at the BHC.”

Thanks to the evolution of mastectomy techniques and the ability to assess blood supply in real time using SPY Elite fluorescence angiography, plastic surgeons can now place an implant in front of the pectoralis major muscle instead of partially underneath it.

“Typically, plastic surgeons use the pectoralis major muscle to partially cover the implant out of concern for the healing of the overlying skin,” Dr. Harris says. “However, we now have a fluorescence imaging device that provides a real-time picture of the blood supply to the skin. In cases when the blood supply after mastectomy is healthy, we can consider placing the implant in front of the pectoralis major instead of underneath it because we’re less concerned about the blood supply and don’t need the extra coverage for the implant. This new approach leads to significantly less discomfort after surgery, more rapid recovery and, potentially, a better aesthetic outcome.”

Autologous fat grafting is another form of breast reconstruction for which the BHC offers some of the latest advances in the field. This technique involves harvesting fat, typically from the abdomen and flanks, and grafting it into the breast to enhance the aesthetic outcome, according to Dr. Harris. Harvest and grafting take place during a single procedure.

“We use autologous fat grafting to smooth the interface between an implant and normal breast tissue, or to enhance the contours in autologous reconstruction using the patient’s own tissues,” Dr. Harris says. “Peering into the future, it’s possible that using patients’ own fat may one day be a way to accomplish reconstruction without having to use other techniques.”

Throughout the reconstruction process, the plastic surgeon communicates with the patient’s medical oncologist and primary care physician about the individual’s overall cancer care, healing progression following surgery, potential reconstruction-related side effects and how a reconstructed breast will affect future breast cancer screenings, such as mammograms.

WHAT’S NEXT?
The clinicians at the BHC envision continued growth for the center in both services and multispecialty expertise that reflects its commitment to providing excellent, personalized care from diagnosis to survivorship. The BHC has undergone an extraordinary evolution since its inception and will continue to adapt to meet the needs of its community.

“It is really amazing how our program has grown,” Dr. Green says. “One of the main reasons we’ve been successful is that we provide everything patients need where they are most comfortable: their own community.”

For more information about the BHC, visit goodsamaritan.chsli.org/breasthealthcenter.

Caring for the Whole Patient

THROUGH PARTNERSHIPS THAT the Breast Health Center at Good Samaritan Hospital Medical Center has with the American Cancer Society and local breast cancer coalitions, patients have access to a wide range of supportive services, including:

- Art classes
- Home health
- Journaling
- Nutrition services
- Palliative care
- Pastoral care
- Rehabilitation
- Social workers
- Support groups open to patients newly diagnosed with breast cancer, those undergoing treatment and survivors
- Survivorship care plans issued to patients and their primary care physicians
- Transportation assistance
- Yoga

The major focus of the Breast Health Center team continues to be the education and support. Nurse Manager of the Breast Health Center & Radiation Oncology, Bonnie Edsall, MS, RN, CBCN, CN-BN (left), provides personalized support and acts as a liaison for both the patient and family to the multidisciplinary breast team.