women toward lumpectomy may help reduce CPM use and CPM-associated patient debt, chronic pain, and disability.

Disparate Access to Breast Cancer Screening and Treatment

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INTRODUCTION: Disparities in breast cancer mortality remain despite equalization of screening rates and implementation of patient navigation programs (PNP). Hospital characteristics affect treatment receipt, timeliness, and quality of breast health care. The goal of this study is to examine differences between patients receiving breast care at an inner city safety-net center (City) vs those at a suburban county medical center (County) in terms of age, socioeconomic status (SES), and timeliness to breast cancer screening.

METHODS: Retrospective analysis in 2,260 women, 40 years and older, compared breast cancer screening stages (time from encounter with navigator, to screening mammogram, additional imaging and/or breast biopsy), from October 2016 through September 2019. The main outcome of interest was timeliness to screening stage completion and barrier assessment. Age distribution, median ZIP code income quartiles, and screening stages were compared between city vs county patients. Cox regression model evaluated the association of these factors with completion of care.

RESULTS: City patients were significantly younger, of lower SES, and more likely not to complete screening despite PNP compared with County patients. City patients took significantly longer to obtain breast screening (49.9 vs 13.7 days, p<0.001) and undergo required intervention, ie additional imaging and/or biopsy (45.6 vs 21.7 days, p=0.002) compared with County. Cox regression analysis found center location, screening stage, age, and income to be most important variables associated with timeliness to breast cancer screening completion (p < 0.001; Fig. 1).
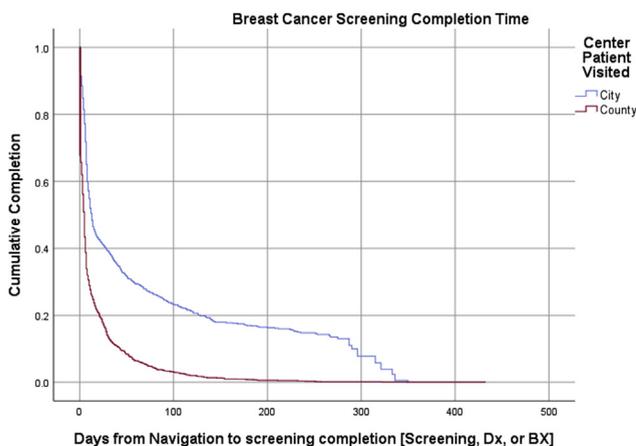

Figure.

CONCLUSION: Breast cancer screening delays were longer at City medical centers serving lower SES and minority populations despite the implementation of PNP. Safety-net hospitals must address inherent barriers associated with SES affecting access to breast care and cancer outcomes.

Disparities in Screening for Breast Cancer Based on Limited Language Proficiency. A Retrospective Cohort Propensity Score Matched Study

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INTRODUCTION: While disparities in breast cancer screening have been studied, the impact of language barriers has not been specifically looked at in a national database.

METHODS: The 2015 sample of the National Health Interview Survey (NHIS) database was retrospectively reviewed. Only patients over 40 years old, with language variable available were included. Univariate and multivariate regression analysis were performed. Lastly, a propensity-score match (PSM) 1:1 was used.

RESULTS: A total of 9,948 patients were included. Prevalence of LEP was 10.09% (N=1,004). Limited English proficiency (LEP) patients reported fewer screening mammograms overall (77.89% vs 90.12% English speakers, p≤0.001), fewer benign lumps removed (7.97% vs 18.73%, p≤0.001), and fewer mammograms in the previous year (50.84% vs 54.07%, p=0.034). Also, higher rates of underinsurance (p≤0.001), higher rates of living below the poverty line (12.36% vs 33.63%, p≤0.001), and lower BMI (30.05% vs 31.79% p=0.0129). LEP patients had older first live births (21 y vs 19.2 y, p≤0.001), lower use of HRT (4.76% vs 17.6%, p≤0.001), older menarche (12.99 vs 12.79, p=0.002) and higher rates of current menstruation (31.52% vs 19.05%, p≤0.001). On multivariate analysis LEP, public insurance and no insurance had lower probability of having screening mammography; while being born in the US resulted in higher probability (Table). After PSM, speaking only Spanish showed lower probability of getting a screening mammography (odds ratio [OR] 0.64, 95% CI 0.43-0.95 p≤0.034).

Table. Multivariate Regression Analysis for Screening Mammogram

Variable	Odds ratio	95% CI	p Value
LEP	0.582	0.438-0.773	<.001
Below poverty line	0.839	0.7-1.006	0.06
Public insurance	0.619	0.512-0.748	<.001
No insurance	0.226	0.186-0.274	<.001
US born	1.283	1.019-1.615	0.034
Hispanic	1.18	0.928-1.501	0.175

CONCLUSION: Addressing the impact of language barriers on screening mammography is of paramount importance in achieving equal health care for the increasing diverse population in the US.

Effect of the Ductal Carcinoma In Situ Margin Consensus Guideline Implementation on Re-Excision Rates, Satisfaction, and Cost

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INTRODUCTION: The 2016 consensus guideline on margins for breast conserving surgery (BCS) with whole-breast irradiation (WBI) for ductal carcinoma in situ (DCIS) recommended 2 mm as an adequate margin. Its purpose was to decrease re-excision rates and cost and improve cosmesis. We sought to compare these outcomes before and after guideline implementation.

METHODS: From an IRB-approved database, patients with DCIS who underwent BCS with over 1 year of follow-up at 1 academic institution and 1 community cancer center were evaluated. Two groups were compared based on when they received treatment, before (pre-consensus [PRE]) and after November 2016 (post consensus [POST]), with respect to outcome and cost parameters.

RESULTS: After consensus guideline implementation, re-excision rate (30.9% POST vs 20.3% PRE, p=0.03) and mastectomy conversion (8.3% POST vs 2.3% PRE, p=0.02) significantly increased, though total resection volume, operative cost per patient, and satisfaction with breast scores did not differ (Table). Not all patients with <2mm margins were re-excised, though re-excision rate among this subset significantly increased (62.4% POST vs 31.3% PRE, p<0.001). On multivariable analysis controlling for age, estrogen receptor status, WBI use, and margin status, surgery

Table. Outcomes after Implementation of Consensus Guidelines for Breast Conserving Surgery for DCIS

Variable	PRE (n=172)	POST (n=181)	p Value
Age at surgery, y, mean (SD)	59.6 (10.6)	62.2 (10.7	0.03*
Total resection volume, cm^3, mean (SD)	100.4 (170.0)	84.5 (101.21	0.42
Re-excision (including conversion to mastectomy), n (%)	35 (20.3)	56 (30.9)	0.03*
Mastectomy conversion, n (%)	4 (2.3)	15 (8.3)	0.02*
Re-excision for margins <2mm, n (%)	25 (31.3)	53 (62.)	<0.001*
Adjuvant radiation, n (%)	155 (90.1)	114 (63.0)	<0.001*
Adjuvant hormone therapy, n (%)	102 (59.3)	106 (58.6)	0.91
Satisfaction with breast score, mean (SD)	67.7 (19.2) (n=48)	64.2 (18.2) (n=13)	0.89
Operative cost per patient, $, mean (SD)	5535.76 (2,153.94)	5754.85 (2,275.96)	0.46

*Statistically significant.

after consensus guideline publication was independently associated with a higher re-excision rate (odds ratio [OR] 1.92, 95% confidence interval [CI] 1.03-3.57, p=0.04).

CONCLUSION: Implementation of the 2016 margin consensus guideline for DCIS resulted in an increase in re-excisions and mastectomy conversions at 2 institutions, opposite to its intended effect. Research is needed for operative tools and strategies to decrease DCIS re-excision rates.

Examining Nationwide Morbidity, Readmission, and Cost of Contralateral Prophylactic Mastectomy with Immediate Breast Reconstruction among Women with Breast Cancer

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INTRODUCTION: Previous data have shown increased complications among women who undergo contralateral prophylactic mastectomy (CPM) with immediate breast reconstruction (IBR) for unilateral breast cancer (BCA) with conflicting data regarding oncologic benefit. However, nationally representative data examining both inpatient and longitudinal outcomes are lacking. We aimed to compare the nationwide morbidity and health care use associated with CPM.

METHODS: Women undergoing mastectomy for BCA and IBR, discharged alive, were identified using the Nationwide Readmission Database 2010-2015. BRCA and incomplete follow-up cases were excluded. Propensity length of stay (LOS), and costs between unilateral (UM-IBR) and bilateral mastectomy with IBR (BM-IBR). Logistic/Cox regression and generalized linear models were used to determine examine outcomes of interest within 180 days.

RESULTS: There were 82,153 eligible patients; 22,969 were matched. Of these, 50.4% underwent BM-IBR. Cohorts were well balanced in patient and hospital characteristics (all p>0.05, bias<5%). BM-IBR was associated with increased complications, cumulative LOS, and costs relative to UM-IBR (p<0.01). The increase in cost was driven by the initial surgery and not by readmissions/reoperations.

CONCLUSION: Consistent with previous studies, we have demonstrated, at a national level, that patients who undergo CPM experience increased morbidity during the index hospitalization. This strategy results in higher nationwide health care use due to the index procedure and not due to readmissions. Surgeons should discuss these data with patients who are considering CPM.