

surgery and explaining the benefits of same-day discharge with other providers at your facility. Themes and representative quotes are presented in Table 1. CONCLUSIONS: We identified novel barriers to same-day discharge after MwoR. These barriers are potentially targetable with interventions addressing patient anxiety surrounding drain management, and education of providers across the care continuum.

Table 1. Interview Themes using the Tailored Implementation of Chronic Disease Framework with Representative Quotes

Themes	Perceived barriers	Quotes
Individual health professional factors	Practice standards and preoperative expectation setting	"What I usually say to my patients is, you'll probably stay in the hospital overnight. They would probably be fine leaving the same-day but that's just not how we've practiced. Perhaps the best thing that I could be doing is being more directed with the patients in the preoperative setting." (Participant 7)
Patient factors	Patient anxiety on drain management	"It's just taking care of the drain that seems to intimidate a lot of people, there's really no reason to stay. But, it's hard to get that expectation established amongst the variety of staff that are interacting with the patient." (Participant 3)
Professional interactions	Facility practice standards at their facility	"As a resident, I worked at a place that didn't keep anybody overnight after mastectomy and I was kind of surprised to find that not to be the case at my current facility. Sometimes it feels difficult to discharge a patient even when you think there's no indication for admission... And so then, you kind of feel like an odd man out." (Participant 3)
	Providers and staff lacking knowledge about benefits of same-day MwoR	"I discharged patients the same-day in residency, but when I came here, I think what was challenging to implement this throughout the practice was other providers and staff didn't know this is how other people are practicing so they weren't settling that expectation with patients. I figured it wouldn't take any extra resources, and since the research and my previous experience didn't suggest any increased risk for patients, I just created a sheet explaining how other facilities were discharging patients the same-day and the potential benefits. They seemed thankful for this and now we are discharging most patients the same-day." (Participant 4)

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Survival Impact of Intervention to Distant Metastatic Lesions in Patients with Breast Cancer Hira Abidi, MD (Presenter;Submitter;Author) - University of Pittsburgh Medical Center; Oluwaseun Ayoade, MD (Author) - Yale School of Medicine; Emilia Diego, MD (Author) - University of Pittsburgh Medical Center; Priscilla McAuliffe, MD, PhD (Author) - University of Pittsburgh Medical Center; Ronald Johnson, MD (Author) - University of Pittsburgh Medical Center; Joanna Lee, MD (Author) - University of Pittsburgh Medical Center; Donald Keenan, MD, PhD (Author) - University of Pittsburgh Medical Center; Jennifer Steiman, MD (Author) - University of Pittsburgh Medical Center; Efe Sezgin, PhD (Author) - Izmir Institute of Technology; Atilla Soran, MD, MPH (Author) - University of Pittsburgh Medical Center

INTRODUCTION: Approximately 25% of patients (pts) with stage I - III breast cancer (BC) develop distant metastatic disease, a significant cause of mortality. The aim of this study is to evaluate whether intervention to metastatic lesions, in pts initially presenting with stage I-III BC, impacts overall survival (OS) and post-distant recurrence survival (PDRS). METHODS: This is a single-institution retrospective study of 201 pts with stage I-III BC, who subsequently develop metastatic lesions to the liver, lung, and/or bone, from 2006-2016. The cohorts included pts receiving intervention to their metastases (IM, n=100) versus no intervention to their metastases (NI, n=101). Two pts in the IM group were lost to follow up and excluded from the survival analysis. The primary study outcomes are OS and PDRS. The characteristics of the pts were compared with X2 test. OS curves were calculated by Kaplan-Meier method and multivariable analysis by Cox regression. Statistical significance was set at p< 0.05. RESULTS: Pts in the IM group were younger (54±14 yrs) than in the NI group (57±14 yrs p=0.03). BMI, menopausal status, hormone receptor and HER2 status, and site of metastatic lesion were not significantly different between the two groups. For OS, the IM group had 34% lower hazard of death than the NI group (HR 0.66; 95%CI 0.49-0.90; p=0.008). For PDRS, the IM group had 33% lower hazard of death than the NI group (HR 0.67; 95%CI 0.50-0.92; p=0.01). Median OS and PDRS were significantly longer in lung metastases with intervention compared to without intervention. On multivariable analysis, OS was improved among pts with IM, a distant-disease free interval (DDFI) of at least 2 years, and those with bone or liver metastasis versus lung or multi-site metastases. CONCLUSIONS: In this cohort of pts with stage I-III BC, who subsequently developed metastatic disease to the bone, liver or lung, intervention to the metastatic lesion had an OS and PDRS benefit. Pts with limited metastases, and in those who have DDFI of at least 2 years after initial breast surgery should be discussed at a multidisciplinary tumor board to explore options for interventions to their metastases.

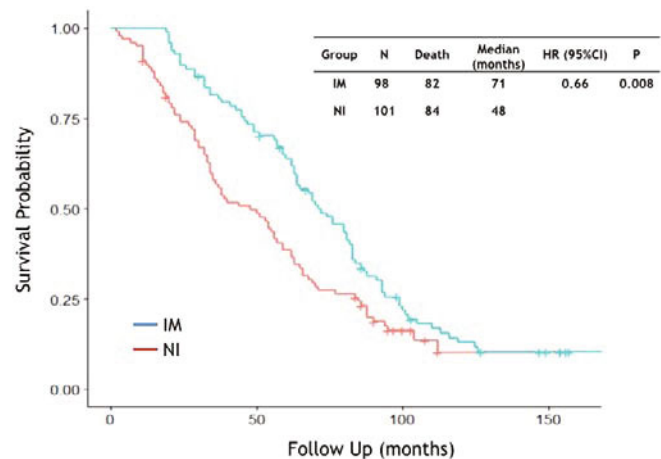


Figure. Overall Survival in Patients with Breast Cancer Receiving Intervention to Metastatic Lesions (IM) Versus No Intervention (NI)

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Take it or Leave it – Values of Women Choosing Breast Conserving Surgery Over Mastectomy Anna M. Chichura, MD (Presenter; Submitter; Author) - NorthShore University HealthSystem & the University of Chicago; Kyra Nicholson, MD (Author) - NorthShore University Health System & the University of Chicago; Kristine Kuchta, MSc (Author) - NorthShore University Health System; Catherine Pesce, MD (Author) - NorthShore University Health System & the University of Chicago; Katherine Kopkash, MD (Author) - NorthShore University HealthSystem & the University of Chicago; David Victorson, PhD (Author) - Northwestern University Feinberg School of Medicine; Deanna Attai, MD (Author) - David Geffen School of Medicine at UCLA; Katharine Yao, MD (Author) - NorthShore University HealthSystem & the University of Chicago

INTRODUCTION: Factors influencing the decision-making process for bilateral mastectomy (BM) have been well described, but there is limited information characterizing decision-making for BCS. METHODS: An electronic cross-sectional survey assessing patient demographics, tumor factors, treatment preference and values, and the "Big 5" personality trait profile was distributed to Love Research Army volunteers ages 18-70 who underwent BCS, unilateral mastectomy (UM), or bilateral mastectomy (BM) for breast cancer (BC) from 2009 to 2020. Treatment preferences and values were based on individual one-hour qualitative interviews with 15 women who had BC treated at our institution. Multivariable logistic regression adjusted for age, family history, and stage was used to determine the treatment preferences and values associated with BCS. RESULTS: 1522 survey responses were complete and analyzed. BCS was performed in 676 women (44.4%), UM in 327 (21.5%) and BM in 519 (34.1%). Women who had BCS were more likely to be older (51±8 v 48±8, p< 0.001) and have early-stage BC (88.9% v 80.2%, p< 0.001). There were no significant differences in personality traits between those undergoing BCS versus UM or BM. The top 5 reasons for choosing BCS were "following the doctor's recommendation" (81%), "have the fastest recovery" (73%), "best chance for longest life" (72%), "keep as much of the original breast" (64%) and "get all the cancer out" (60%). "Best chance for longest life" and "get all the cancer out" were the only common values between BCS and BM patients. On multivariable logistic regression, the top 3 values associated with BCS choice were "keep as much of the original breast" (OR 2.92 (2.2-3.87)), "following the doctor's recommendation" (OR 2.52 (1.84-3.45)), and "wanted the least invasive procedure" (OR 4.01 (2.86-5.6)). CONCLUSIONS: There is no one personality trait associated with the decision for BCS, but patients choosing BCS highly value their doctor's recommendation, highlighting the importance of the patient-physician relationship in the decision-making process for women undergoing surgery for BC.