[00:00:00] **Stephen Calabria:** From the Mount Sinai Health System in New York City, this is Road to Resilience, a podcast about facing adversity. I'm your host, Stephen Calabria, Mount Sinai's Director of Podcasting.

[00:00:12] On today's episode, we welcome Elisa Port, MD, FACS. Dr. Port is the director of the Dubin Breast Center at Mount Sinai, a global leader in the screening, treatment, and survivorship of breast cancer.

[00:00:24] She's also the Chief of Breast Surgery at the Mount Sinai Health System, and the author of the New Generation Breast Cancer Book: How to Navigate Your Diagnosis and Treatment Remain Optimistic in the Age of Information Overload.

[00:00:37] On this episode, Dr. Port discusses the latest research into breast cancer treatment, how patients navigate the most challenging circumstances following a diagnosis, and the resilience lessons her patients continuously have to offer.

[00:00:49] We're honored to welcome Dr. Elisa Port to the show. Dr. Elisa Port, welcome to Road to Resilience.

[00:00:56] **Dr. Elisa Port:** Thank you. Happy to be here.

[00:00:57] **Stephen Calabria:** You are the director of the Dubin Breast Center of the Tisch Cancer Institute at Mount Sinai. Could you share a little bit about what it is that your center does?

[00:01:06] **Dr. Elisa Port:** Sure. My center and in fact all of Mount Sinai, because we have a number of other centers where people can go and get comprehensive breast health care does just that.

[00:01:18] Of course, we're very focused on the treatment and cure of breast cancer. That's our number one priority, but we also see patients who are at high risk for breast cancer.

[00:01:28] Or, who have other breast related health issues. What we do in our centers is what a lot of people don't realize, is that breast health can involve a lot of different components.

[00:01:41] It can involve imaging, like mammograms or ultrasounds. It can involve surgery, taking something out, cancer or normal. It can involve radiation, chemotherapy, different types of medicines, genetic testing.

[00:01:55] Plastic surgery. And so what we do in these centers is sort of commandeer and provide multidisciplinary breast health care tailored to the individual and her needs.

[00:02:07] **Stephen Calabria:** Who is most likely to get breast cancer? And what are the most common paths to its diagnosis?

[00:02:13] **Dr. Elisa Port:** Sure. So what a lot of people don't realize is in general, breast cancer is a disease of elderly women. About 75 percent of cases are diagnosed in women over the age of 50.

[00:02:26] And the average woman who gets breast cancer in this country is in her 60s. But there's any, any age group can get breast cancer. About 5 percent of cases develop in women under the age of 40.

[00:02:38] So it's very, very rare in younger women, but certainly we see it. The things that put a woman at increased risk for breast cancer, first we need to understand that.

[00:02:48] Believe it or not, about 85 to 90 percent of women who get breast cancer have no identifiable risk factor. And I think that's super important to share.

[00:03:00] It's a huge misconception that the only people who are at risk are those who have a family history, who have had prior issues, etc. That's just not true.

[00:03:12] Every single week, someone walks into my office with a new diagnosis of breast cancer saying, How did this happen? I didn't even realize I was at risk.

[00:03:20] So, 12 percent of women get breast cancer over their lifetime, so if you're a woman, you're at risk. And it increases with age, although no age group is really off the hook.

[00:03:32] In general, most women in 2024 are diagnosed if they're screened regularly, as they're supposed to be, which is yearly mammograms, starting at age 40.

[00:03:42] That pathway to diagnosis gives one the best chance of survival and the highest likelihood of cure. And that's because mammograms, ultrasounds,

imaging. does pick up cancer earlier when it's infinitely more treatable and curable.

[00:04:00] Women who aren't getting screened would typically be diagnosed through some kind of physical symptom that they or their doctor identify.

[00:04:10] So of course the most common would be a lump or changes in the skin, a discharge from the nipple inversion. What's called skin dimpling, tethering in of the skin from an underlying cancer.

[00:04:22] So these are all the physical exam findings that should always be brought to a physician's attention, even if one is getting screened.

[00:04:31] **Stephen Calabria:** And they are ones, presumably, that patients could do on their own regularly.

[00:04:35] **Dr. Elisa Port:** Absolutely. Believe it or not, it's shocking to believe this, that even breast self exam has come under some scrutiny related to its validity. There's a lot of guidelines out there that are incredibly patronizing and even insulting.

[00:04:53] The United States Prevention Service Task Force recommends against breast self exam. And I turn around and I say, yes, I understand women can feel things. And get nervous about things.

[00:05:06] But, women are not histrionic. They don't overreact in general. And no one would ever say to a human being, Don't be familiar with what's normal for your body.

[00:05:20] We tell people all the time, Do skin checks, look for new moles, etc. Why is this any different? A human being, male or female, should be

[00:05:29] As familiar as possible for what it with what is normal for them so that if God forbid there's a change, a new mole on your skin, a new lump in your breast, anything you would be aware enough and self-aware enough to bring this to the attention of a doctor.

[00:05:47] And I just don't see how there can be much downside to that.

[00:05:50] **Stephen Calabria:** Right. You would think that the emphasis should be on overprotection.

[00:05:55] **Dr. Elisa Port:** No. It's early detection. You're right. On erring on the side of caution. I couldn't agree more.

[00:06:01] **Stephen Calabria:** Breast cancer may, of course, be a life altering diagnosis. How do you see resilience manifesting in your patients throughout their treatment cycle?n

[00:06:10] **Dr. Elisa Port:** Yeah, I mean, it's, it's obviously such an honor to be part of a patient's journey and to take them through this, and I see it manifesting in a lot of different ways.

[00:06:22] I think big life changes can be a wake up call for human beings, and there can always be a silver lining.

[00:06:31] I've had patients who have left bad relationships or toxic relationships because they felt, wow, this is a wake up call that my life, my life and my luck can change on a dime, and anything can happen and there are no guarantees.

[00:06:48] So like the whole life's too short cliche, you know, leave a bad relationship, start a new one. Leave a bad job, take a new one. Interact differently with, with humans in their life..

[00:07:01] Take up a new hobby. Make lifestyle changes. Very important. It's really interesting because, smoking is not really considered a main risk factor for breast cancer.

[00:07:12] So, with all honesty, I, I really don't have the grounds to stand on to tell someone, you have to stop smoking or your breast cancer is going to come back.

[00:07:20] But here's what I do know. Lung cancer and smoking-related illnesses like heart disease, these are the number one killers of women above breast cancer.

[00:07:33] And so if I can get a woman who is diagnosed with breast cancer to stop smoking, as part of it, I, I tell her, I may have saved your life twice. And I think those are really, really amazing, teachable moments.

[00:07:50] We've had patients who have very, very heavy, drinking habits, alcohol problems.

[00:07:55] We've had patients go to rehab at the time of their cancer diagnosis, to undergo rehab for a month and then have their breast cancer treatment and have never gone back to it.

[00:08:06] Weight is a huge issue with breast cancer being overweight or obese definitely puts you at higher risk for recurrence or getting breast cancer in the first place.

[00:08:15] What a lot of people don't realize is that fat stores can actually produce hormones, and hormones can lead to breast cancer growth, so the more fat stores that one has, the higher the estrogen levels the body may see, and that can certainly contribute to breast cancer recurrence, so, I tell women who are, we try not to do this when they are in active treatment, because as you can imagine, some of these habits, you know, whether it's overeating or smoking, these are crutches that people turn to in some of their most difficult moments.

[00:08:51] And when you're diagnosed with breast cancer, that qualifies as a very difficult moment. So, as part of the recovery process, we like to broach the issue and talk to people about lifestyle changes that they can make.

[00:09:04] And we give them the framework to do that. We have a full time nutritionist on staff, obviously we talk to patients about medications, all kinds of things that they can do to support them in making lifestyle changes. So I think that's part of resilience.

[00:09:19] **Stephen Calabria:** Well, so many of these changes you're talking about are behavioral ones. And what role, specifically, would you say emotional and psychological support play in the breast cancer treatment process, especially at the Dubin Breast Center?

[00:09:31] **Dr. Elisa Port:** Yeah, I think it's a really good question. I think, you know, there's so much, when people hear the word cancer, obviously there's so much fear involved.

[00:09:41] And the first question that people often ask is, Am I going to die? And I try to reframe that question, say, you can die of breast cancer, just like you can die walking across Fifth Avenue and getting hit by a bus.

[00:09:56] And for a lot of people, what's super interesting is, is that a cancer diagnosis can be, for some people, the first time that they are coming face to face with the concept of loss of control or uncertainty that existed sort of all along.

[00:10:15] And I try to instill in people a sense of optimism that they are going to be okay, and they have an incredibly high chance of survival. Thankfully in breast cancer we can do that. There is so much room for optimism, more than ever before.

[00:10:33] And you know what I tell people is, look, I'm, I'm old now, I've been doing this for 25 years. And in the beginning, you don't have the benefit when you're just starting out in practice of seeing people coming back 5 years later.

[00:10:48] And what I say to people is, the thing that people regret is, having lived in fear all that time of recurrence. It may happen. It probably won't. But what's for sure is that there's definitely a compromise in quality of life if you're constantly living in fear of recurrence.

[00:11:09] And again, it's like everything in life. You can get in a car, everyone knows someone who died in a car accident, yet if every time you got in a car and you went on a long drive, you thought about, am I going to die? It would be paralyzing. You know, you do the things that you do.

[00:11:26] You put on your seatbelt, you make sure you don't drink and drive, you make sure you don't text and drive. You do all the basic things, but you can't control if, you know. So, I, I try to treat breast cancer like that.

[00:11:37] Get the treatment you need. Don't cut corners. If a doctor recommends X, don't say, I don't need X. Because those are all the things that reduce your chance. of recurrence, and improve your survival.

[00:11:49] There are medicines that we give to breast cancer patients that literally cut your risk of recurrence by 50%. 50%. They're incredibly effective. And yet some patients don't want to take them. They say, you know, side effects, blah, blah, blah, I can't sleep, my leg hurts.

[00:12:07] I get it, we all want the highest possible quality of life, but these medications do work and often cutting corners on the treatments that are recommended lead to bad outcomes, and people don't really hear about those.

[00:12:21] **Stephen Calabria:** We talk on this show also, to your point about optimism, about realistic optimism, the role that that plays in, in resilience.

[00:12:29] How do you approach conversations about increased recurrence,, with certain patients versus others? Getting patients to see the situation as it is and not necessarily how they wanted to be?

[00:12:43] **Dr. Elisa Port:** In. You mean in a good way or in a bad way?

[00:12:46] **Stephen Calabria:** In a neutral way. Presenting things as they are to the patient.

[00:12:48] **Dr. Elisa Port:** Yeah, I mean, I think the one thing about breast cancer is, obviously we've been treating it and taking care of it for, hundreds of years and we have a lot of data over the last more than 50 years. So I think statistics that we have are very, very powerful.

[00:13:07] If you tell someone you have the kind of breast cancer where there's a 1 percent chance of recurrence, how could you not be optimistic about that? I guess you could find a way if you were really of the most pessimistic type ilk.

[00:13:21] And I think sharing statistics and numbers can put things in perspective to people. But again, those numbers can work different ways if you're a glass half full or glass half empty kind of person.

[00:13:33] You know, I think what I find, which is super interesting, is I think most people, if you tell someone they have a one or two percent risk of something really bad happening, think that's a low enough number that they can live with.

[00:13:48] Conversely, what's interesting is when you start getting into double digits, like 10 percent, most people get very nervous about that. That's like a number, right? I think what's super interesting is, so here we have one two percent, here we have ten percent. It's those numbers in between which really people differ in.

[00:14:07] As you start getting into three and four and five and six and seven, people are all over the map. This is a high number, this is a low number, this is a high risk, this is a low risk, and what they want to do and what they're willing to do to mitigate that risk.

[00:14:21] There are people who say, oh, an 8 percent chance of cancer recurrence. That's not that high. That means I have a 92 percent chance of it not, right?

[00:14:29] And they may use that number if they're comfortable with it to say, yeah, I don't need to take that treatment to lower that because I'm comfortable with that number. On the other hand, you have a person who's like, what? I have a 3 percent chance of recurrence?

[00:14:42] I will do it whatever it takes to knock that number down even further if possible. And so I find that to be that's what makes my job so interesting is really it's so collaborative. I always tell patients I'm the expert in the cancer, but you're the expert in you.

[00:14:58] And there's this range of options where people really do have say. As they used to tell us in kindergarten, you are the boss of you. Kids say, I am the boss of me, right? And people do get to choose what they want.

[00:15:11] We get to make the recommendations, but they get to walk out and decide based on their own value system, their own priorities, all those things, what they decide to do. And that's, it's just such an honor to be involved in a care model like that.

[00:15:25] **Stephen Calabria:** Well from that collaborative aspect, it seems like it takes a village to defeat cancer, especially breast cancer. From what you've observed, is there a correlation between patients' quality of life and the levels support they receive from their families and loved ones?

[00:15:39] **Dr. Elisa Port:** Sure. Of course. I mean, one of the saddest things for me is when I'm operating on someone and they come in. And I say to them, I, I say to every patient before surgery, who's here, who can I call after I'm done with surgery to let them know everything went well?

[00:15:59] And when you're in the recovery room and to tell them they can either come pick you up or you'll be going to your room in the hospital. And every once in a while I'll have someone say, you know, really, I don't have anyone.

[00:16:10] I'm going to have my, I'm going to have an Uber pick me up or I'm going to get a car service or whatever. And, I just always find that to be so sad that, that there's no one really looking out for you or caring for you, what have you.

[00:16:22] So I do think, it takes a village and I think that, people again do this differently. Some people like to keep the circle very tight, you know, one or two friends or one or two family members.

[00:16:33] And for some people it does take the village, you know, it's family members and friends and community bringing over trays of food and you know and helping with housework and helping with all the things that people can't do

for themselves either in the recovery process from surgery or during chemotherapy.

[00:16:51] Taking kids to school, all the things that someone may not be able to do in full capacity during cancer treatment.

[00:16:59] You know, I think that, though, sometimes the only thing I always caution people is, is that, casting a very wide net, there's a lot of information out there on breast cancer, and it can lead to a lot of, I call it, bringing the peanut gallery into the conversation.

[00:17:16] And it can be harder on people, too, to make decisions when there's a lot of people involved. So it's a balance. It really is.

[00:17:22] **Stephen Calabria:** I also imagine, too, because your patient population is significantly older, I would assume that their children are also significantly older. They're working. They have child care obligations They might not be able to be as present as they would like to be in the treatment.

[00:17:38] **Dr. Elisa Port:** Everyone. You know, to your point, exactly your point what I always say is, you know, breast cancer never comes at a convenient time. No one has ever walked into my office and said, gosh I can do this now, I actually had nothing planned

[00:17:52] No one has ever said that people have plans. They have trips. They have family celebrations. They have so many things. And, it's all, all becomes workarounds and again, what I try to tell people is I'm not a huge fan of missing the best things in life for the worst things in life.

[00:18:11] So one of the forgiving things about breast cancer is, there is a lot of built in flexibility. It's not like you show up in the emergency room and you need an operation within the next three or four hours, or you could die. It could be in two weeks or three weeks or , there is some built in flexibility.

[00:18:27] So we really, I think we do this really well at, at Sinai and at the Dubin Breast Center and our surgeons are just very, humanistic in our approach and empathetic and trying to work with our patients to navigate around life to do what we need to do.

[00:18:46] **Stephen Calabria:** Well, also to take a holistic view of a patient's overall health. You were talking earlier about. How obesity plays a factor, is a

factor, heart disease is a factor, so you're not just looking at that cancer, you're looking at the patient as a whole and what is best for that patient.

[00:19:04] **Dr. Elisa Port:** Absolutely. You can't, you can't look at the breasts in a vacuum. Really, it's part of the whole body and you really want to do what's best for people long term.

[00:19:15] **Stephen Calabria:** The medical field, especially oncology, I imagine can be incredibly demanding. In terms of being demanding, how would you say breast cancer is unique among medical providers?

[00:19:27] **Dr. Elisa Port:** Yeah, I've thought about this a lot. And I think what I've come up with is, there are very few other specialties, especially in surgery, where the decision making between the relationship between the doctor and the patient is so collaborative.

[00:19:45] When someone has lung cancer, for example, my husband's a lung cancer surgeon. They come into his office. He tells them, he doesn't ask them, Do you want me to remove this much of your lung or that much of your lung?

[00:19:58] It's a decision that he makes based on the anatomy, whatever, and even if there was a choice, from the outside, no one would know. Right. If you had a lobectomy or a segmentectomy or the whole lung removed, right?

[00:20:13] It's not something you wear on the outside. The same is true with a colon cancer surgeon. No one tells their colon cancer surgeon, I want you to remove this much or that much. It, and again, no one would know.

[00:20:27] With breast cancer, not all, but most women have options. A lumpectomy and a mastectomy are associated for most patients with absolutely the same survival. And we can educate our patients about what you get with one versus what you get with the other.

[00:20:46] But in general, it is a patient's decision. And, I view our job as much more collaborative. I don't walk into a room and tell a patient, you're having a lumpectomy or you're having a mastectomy. There are times when there really is only one safe option.

[00:21:03] And I tell them that, but for the majority of our cases, there's lots of options. Even women who must have a mastectomy on one side, sometimes there's a choice. Do they want to or need to remove the other breast? So, there's a lot of options and a lot of collaboration.

[00:21:19] I don't know any other disease process where it's that many options that you kind of discuss together and reach a plan with together.

[00:21:29] **Stephen Calabria:** Well, I imagine that also presents its own array of challenges for you as the provider. I mean, there are social components involved, cultural components. Breasts are different from colons and lungs in the sense that there are a great many social factors that, you know.

[00:21:48] **Dr. Elisa Port:** How about just breastfeeding? I mean, we, when we have our young women who are diagnosed with breast cancer or our young patients who are BRCA mutation carriers. I just came from a surgery where I did a prophylactic mastectomy on a young woman who has the BRCA gene.

[00:22:03] I mean, she has a 90 percent chance, 80 to 90 percent chance of getting breast cancer over her lifetime. And she elected to remove the tissue to prevent herself, to reduce her risk of getting breast cancer down to 1%.

[00:22:16] The trade off for that, because she did it at a young age, is a decision she will no longer be able to breastfeed. And when you make those kinds of decisions, it's not only attractiveness and sensation, which can be a huge part of sexual function for women, it's also functionality.

[00:22:32] You cannot breastfeed after you have a bilateral mastectomy. So it's, there's so many different factors to your point in the overlay of decision making.

[00:22:41] **Stephen Calabria:** And in a situation like that, does the Dubin Breast Center provide any kind of psychological counseling for that?

[00:22:49] **Dr. Elisa Port:** We sure do. For some women, it's a much more straightforward choice. But for women who are really having, especially women, for example, who never wanted, you know, the lumpectomy is an easier choice, because it's much less disfiguring.

[00:23:02] For women who are choosing a mastectomy or a bilateral mastectomy, or worse, have to do that because of the size or extent of disease, it can be harder to wrap your head around. It is a loss. It's removing a body part. And for some women, it's an incredibly important, central body part.

[00:23:20] Central to their identity, their sexuality, their femininity, all of those things. Look, there's a reason why millions of women every year are get breast augmentation. They do that.

[00:23:32] That is a plastic surgical surgical procedure that women pay money because it's not, obviously, covered by insurance to do to make their breasts larger. So we know that there's a significant proportion of the population that views breasts, or larger breast size, has a component to attractiveness.

[00:23:53] **Stephen Calabria:** And because so many of these decisions are so personal and so much of the collaboration that happens between you and your patients is unique, especially to your area, I imagine there is also an enhanced sense of closeness between you and your patients.

[00:24:11] How do you and your team maintain your own resilience prevent burnout when you have to get so close to your patients?

[00:24:20] **Dr. Elisa Port:** I mean, I, I think, thankfully again, our results are quite excellent. But I think when something, bad happens to a patient, and we all have them, it's, it's really, it's really, really devastating to us too. In cancer in general, there's a spectrum of seriousness of diseases.

[00:24:42] There's some other kinds of cancer where the survival is much more dismal. The prognosis is dismal. I'm not sure I can do that. I think I gravitated toward a specialty where there is so much room for optimism and it was growing when I started out.

[00:24:57] Between 2000 and 2010, I started in practice in 1999. Things were already happening that were really exciting. And then starting a year after I practiced. Between that ensuing decade, the death rate from breast cancer dropped like 2 percent each year.

[00:25:17] So if you're diagnosed like in the last, let's say, 14 years that I've been practicing, the survival rate was 20 percent higher than when I first started practicing. And that trend has continued. The survival rate is like 40 or 50 percent higher than in the 1990s.

[00:25:36] And the resilience is also, remember, there are bad results that are not devastating too. You do a lumpectomy and we find out a week later for many patients whether we got clear margins or not.

[00:25:49] One of the hardest conversations I still have to have with a patient is, no one wants a second operation. And in the lay person's understanding of surgery, it's one and done. It should be. That's not the way it is for us.

[00:26:05] You know, a lumpectomy can be a process. I just did an operation that was a lumpectomy. I can't see or feel anything when I'm in there. I'm very optimistic I got it all out, but a week from now I'll get the report.

[00:26:17] And if we didn't get it all out, because under the microscope it showed that the cancer was more extensive than we thought, it's really hard.

[00:26:24] It really weighs on us to walk into a room and deliver bad news and say, look, you're not going to die from this, but you need more surgery. It's very disappointing. I say it's disappointing, though it's not devastating.

[00:26:37] And we have to insulate ourselves from that, too, because giving bad news or complicated news and making sure we keep our chin up and we, our patients keep their chin up in the face of unexpected bad news is super important part of the job.

[00:26:53] **Stephen Calabria:** Not to go down a couple of rabbit holes here.

[00:26:57] **Dr. Elisa Port:** Sure.

[00:26:57] **Stephen Calabria:** I'm curious to know,

[00:26:58] **Dr. Elisa Port:** But let's.

[00:26:59] **Stephen Calabria:** But let's, why not? You were talking about the advancements that you've seen since you started. Do you see any advancements forthcoming with the advent of AI?

[00:27:11] **Dr. Elisa Port:** Such a great question. And the answer is yes. And the answer is we're already doing it. So, Mount Sinai, as a health system, has been on the cutting edge of our radiologic services, which, as everyone knows, is a very important part of diagnosing breast cancer.

[00:27:27] Mammograms save lives, mammography saves lives, it picks up about 85 to 90 percent of breast cancers. That is how most breast cancers are detected.

[00:27:36] Well, what if I told you that 15 years ago when we opened the Dubin Breast Center, 14 years ago, it was when 3D mammography technology was just coming out and our chief of breast imaging, Lori Margulies, who's really been on the forefront of this and had her finger on the pulse of what was going on said, I want this.

[00:27:57] Not only do I want this, I want us to be the first ones in New York to have it. So, 2011, when we opened the Dubin Breast Center, we were the first ones to have 3D mammography. Okay. It is now virtually the standard of care everywhere in the country.

[00:28:16] I should clarify, we were the first ones in New York to have it, New York City. And now pretty much everyone has it. Let's move on to AI. There are a lot of places that are doing AI reads of mammograms. Now we don't do it in lieu of human read. It's almost like a double read.

[00:28:36] And as Dr. Margulies likes to say, you know, AI doesn't get tired. AI doesn't need to go answer a phone call. AI doesn't need another sip of coffee.

[00:28:45] So, we are doing AI reads on almost every mammogram that is done in the Mount Sinai Health System now, and it's free. It's not added cost. There are other places in the city where they're basically monetizing this and they're offering it to patients.

[00:29:02] They're saying, do you want another AI read? And, you have to pay X number of dollars extra.

[00:29:09] **Stephen Calabria:** We discussed the condition and its treatments as well as the patients in your team. Let's talk for a moment about you. Could you share your journey to becoming the head of the Dubin Breast Center and what motivated you to specialize in breast cancer treatment?

[00:29:23] **Dr. Elisa Port:** Sure. So my path to becoming a doctor and being a breast surgeon was kind of circuitous, and I'll give you the shorter version. I did not start out as a pre med in college. I was a language major.

[00:29:37] I did not really do well in the pre meds in college, and so I gravitated toward things that I did really well at. I graduated college speaking four languages pretty fluently and thought I would do something related to that.

[00:29:50] But ended up kind of floundering around and ultimately decided that medical school, which was something I had considered, actually could be a good path for me. And, I thought, you know, even if I wasn't going to be using my Spanish and my French to interpret documents or anything like that.

[00:30:08] Gosh, what better way to use those languages than talking to actual patients, so I would never lose those skills. So I went back and I did a post bac,

which is, after finishing college you go back to complete your pre meds, and I had a lot of work to do, and I did that.

[00:30:23] And got into Mount Sinai Medical School, and even at Mount Sinai Medical School, I wasn't really, like, obsessed with anything until I got to surgery. And then the whole surgery thing just completely overtook me. It was my calling. It was my mission in life.

[00:30:39] I loved working with my hands and my brain. I love the idea that, you could fix things. I became obsessed with the idea of fixing something. The idea that you could take someone into surgery.

[00:30:51] Take out a piece of diseased colon, or a gallbladder, or a fixophrenia, or cure breast cancer, or take out a brain tumor, whatever it was, and have them,

[00:31:01] To this day, it's not lost on me, I just, I just operated on two people, and each one of them, I, you know, I, I, I think to myself during the surgery at some point, This person walked in the hospital with cancer and they're walking out two hours later without it.

[00:31:17] It's like miraculous. It's miraculous. And we're the purveyors of that miracle. We really are. We're purveyors of miracles. And to just be involved in that and to have been granted and to have developed and to have received the training to do that is so rarefied.

[00:31:37] And it's just, it's just such a privilege.

[00:31:39] **Stephen Calabria:** What are your goals for the future of the Dubin Breast Center? Are there certain benchmarks you envision that advance your mission in the coming years?

[00:31:47] **Dr. Elisa Port:** Sure. Well, I would say bigger than the Dubin Breast Center. You know, we're now, as we're Mount Sinai Health System, we have other centers throughout the system. So, Dubin for sure is kind of like our flagship. We need to expand it because the demand is so great.

[00:32:02] We are now a go to, if not the go to, destination for breast cancer care. In the city. in the country, in the world. Tomorrow, I'm seeing a patient who's coming in from London. I'm seeing another patient who's coming in from the Middle East. I'm seeing another patient who's coming in from California.

[00:32:18] The word is out, and we're delivering the highest level of care. And, of course, the paradox to that is we're also taking care of people in our own neighborhood, right in our backyard, and giving them the best level of care.

[00:32:31] So the whole mission of Mount Sinai, which absolutely extends to the Dubin Breast Center and all of our sites is, we take care of everyone regardless of ability to pay. And everyone gets the same level of care.

[00:32:43] So I think not only are we delivering the highest level of care, we're delivering the highest level of care to people who might otherwise not be able to afford it. So that's a huge source of pride. So we need to expand the Dubin Breast Center.

[00:32:55] Separate from that, we have other centers. We just opened a new center on the west side. Mount Sinai West. Beautiful, state of the art breast center. And we want to get people to go there and put that on the map as sort of also a destination. It already is to some degree.

[00:33:11] We have amazing surgeons there. It's led by my partner, Dr. Stephanie Burnick, she's wonderful, and we have two other junior level breast surgeons who are there. We're adding another one, so soon there'll be four working there. We have a space in Chelsea, I go there once a month.

[00:33:28] The Chelsea, the Blavatnik Women's Health Center provides breast cancer services there. And again, full thickness services, radiation and chemo and all those things. And that's an amazing place to go.

[00:33:39] And we also have breast surgeons in Union Square, Morningside Hospital, Mount Sinai Brooklyn and so forth.

[00:33:46] So what I want for the next 10 years is to really expand our footprint through those centers, and to continue to deliver best level of breast cancer care that we can throughout the system, throughout the city, throughout the country.

[00:34:00] **Stephen Calabria:** What do you wish more people knew about breast cancer?

[00:34:03] **Dr. Elisa Port:** Again, I wish more people didn't listen to conspiracy theories and misinformation about screening. Not even that, but the misinformation that's put out even by the United States Prevention Service Task Force.

[00:34:18] I'll probably get into trouble for this, but they just changed their mammography recommendations. Finally, after about 10 years, they are acknowledging what we knew all along, that mammograms should start at age 40. So, they were at age 40.

[00:34:35] And then in 2009, they changed, they're like, No, we don't think that mammograms between 40 and 50 are so useful, maybe do more harm than good, et cetera. They were motivated by factors related to harms from mammogram, like false alarms and quite frankly, cost-saving.

[00:34:54] Let's just call it what it was. The number of mammograms you had to do to detect one cancer and the number of biopsies you needed to do was in their judgment, prohibitive, that doesn't reverse the fact that mammograms in that age group did save lives.

[00:35:11] And so they chose to deprioritize lives saved. and favor instead, cost savings, and so forth. And that was evil, okay? And there's no telling how many lives were jeopardized or how many lives were cost in this intervening, 15 years that it took them, to come back around, that mammograms every year, starting at age 40, do save the most lives.

[00:35:39] Now, what they didn't do is they didn't go far enough. They were at mammograms every year, and that's what the data shows, that every year saves the most lives. They said, let's not do them every year. Let's do them every two years.

[00:35:52] The lunacy of that approach is that, what they acknowledge is part of the reason they reverted back to their original recommendations is, they said, A lot of young women get aggressive breast cancer, so we should screen for those.

[00:36:09] Well, aggressive breast cancer equals fast growing breast cancer, and cancer that can progress rapidly.

[00:36:19] So, saying we're going to start doing mammograms again at age 40 for fast growing breast cancers, aggressive breast cancers, but we're only going to do it every other year is so contradictory and so hypocritical and actually speaking out of both sides of our mouth.

[00:36:38] Two years, a lot can happen in two years. A lot of progression of cancer can happen. So don't tell us, you should do mammograms starting at age 40 because they do develop cancers that are more aggressive, but then only do it every two years.

[00:36:52] It absolutely makes no sense to any of us, and it's just not what we see. I think the other thing that I would hope people realize is that they think that there's so many breast cancer experts involved in these recommendations and it's thought over and people like me who are in the trenches are the ones responsible and we've weighed all the evidence.

[00:37:13] There's not a single me or someone like me that's involved in these recommendations. Okay, there's not a single breast cancer specialist who is involved in the United States Prevention Service Task Force.

[00:37:28] **Stephen Calabria:** It's what, all bureaucrats?

[00:37:29] **Dr. Elisa Port:** It's, it's public health officials. There's a couple of pediatricians, there's a couple OBGYNs, there's a couple, a lot of primary care people. At one point in the 2009 recommendations, there were people that were actually involved with quote, managed care organizations.

[00:37:49] I think we all know that managed care organizations somewhat prioritize cost. So, I would say, when you're looking at who's making these recommendations, take them with a grain of salt.

[00:38:02] And I think the public has been demonstrably deceived. I think there's a public perception that the people making these recommendations are people who are intimately involved in the care of breast cancer patients.

[00:38:17] And not a single one, not a single breast medical oncologist. Not a single breast radiologist, not a single surgeon. And there's 16 people who authored these things and they turn around and say, well, people like me would be so biased, right?

[00:38:31] Of course, a breast radiologist, but there's bias the other way too. And we're not saying, you know, make the whole panel composed of people, but how about one or two to provide some perspective from what we see in the trenches every day?

[00:38:46] **Stephen Calabria:** Well, we can only hope the powers that be will involve you to a greater extent, and the folks at the Dubin Breast Center.

[00:38:52] Last question. Can you share a piece of advice, or a mantra, that you find particularly powerful in cultivating resilience, both in yourself and patients and perhaps aspiring medical practitioners.

[00:39:06] **Dr. Elisa Port:** Oh my gosh. A mantra.

[00:39:09] **Stephen Calabria:** Just in case that wasn't open ended enough.

[00:39:11] **Dr. Elisa Port:** Yeah. I mean, there's so many. You know, a lot of patients, when, in my first book, when this, the first story I told of a patient, and there's a lot of versions of this phrase.

[00:39:25] Some of them involve profanities, which I won't use here. But, if you look at my first book, the New Generation Breast Cancer book, and you look at the story, I walk the patient in to the operating room and she says to me, and I say back to her, let's do this.

[00:39:40] So, the most, I think, pessimistic, dark time for patients, is the time between when they're diagnosed, and when they have a plan. By the time they come to me in the office, they leave, I feel, much lighter knowing that we have a plan.

[00:39:57] I think not knowing and being in that limbo land can be so scary. So, I think that once, forward motion, let's do this, or let's go. I see patients all the time. They feel, especially in New York where there's so many great hospitals, I need to get this opinion, and that opinion, and a third opinion, a fourth opinion.

[00:40:17] They go into a state of paralysis. And I think, not that there's an emergency, and not that we ever put pressure on people, but at some point, you just have to make a decision. And let's go.

[00:40:33] **Stephen Calabria:** Well, that was it for my questions. Was there anything else you wanted to say?

[00:40:35] **Dr. Elisa Port:** No, no, no. I think this was great. I think it's a beautiful, you know, way of inspiring younger people to tell stories about patience and resilience and, you know, so, so honored to be asked to participate.

[00:40:49] If you're diagnosed with breast cancer or at high risk for breast cancer and would like to see, a breast doctor at Mount Sinai in one of our many locations. You can go online and there's a portal to make appointments and there are also the various phone numbers listed for whichever site you choose to be seen at.

[00:41:10] **Stephen Calabria:** Well, we would love to have you back. Dr. Elisa Port, thank you so much for coming on the Road to Resilience.

[00:41:15] **Dr. Elisa Port:** Thank you.

[00:41:17] **Stephen Calabria:** Thanks again to Dr. Elisa Port for her time and expertise. That's all for this episode of Road to Resilience. If you enjoyed it, please rate, review, and subscribe to our podcast on your favorite podcast platform.

[00:41:28] Want to contact the show or offer us an idea for a future episode? Email us at podcasts at mountsinai. org.

[00:41:35] Road to Resilience is a production of the Mount Sinai Health System. It's produced by me, Stephen Calabria, and our executive producer, Lucia Lee. From all of us here at Mount Sinai, thanks for listening, and we'll catch you next time.