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[Our mission, vision & core values](#)

[Leadership](#)

[History](#)

[Equality, diversity & inclusion](#)

[Annual report](#)

[Give to MSK](#)



Monica Morrow

I've always been interested in anatomy and what's inside the body. When I was in first grade, growing up in suburban Philadelphia, I brought the heart and lungs of a cow to school — which I don't think my teacher much appreciated. I'd gotten them from a butcher for show-and-tell.

Later, I enrolled in a combined five-year college and medical school program at the Jefferson Medical College, in Philadelphia. I soon became attracted to surgery. In the 1980s, I trained as a surgical oncology fellow at Memorial Sloan Kettering and practiced general surgical oncology early in my career before specializing in breast cancer surgery.

Breast surgery is actually somewhat different than many surgical fields — and this is true of a lot of areas of cancer care — in that it involves a great deal of long-term patient interaction. It's also challenging because breast cancer is an extremely complex disease. It's becoming increasingly clear that the underlying biology of breast cancer has a major impact on the outcomes of things we have traditionally thought to be related to the mechanics of

surgery.

For example, there is an ongoing debate about how big a margin (healthy tissue) a surgeon needs to remove when doing a lumpectomy in order to ensure that the cancer will not come back in the affected breast. The debate began when we treated patients only with surgery and radiation.

However, we now know that the use of targeted therapies such as tamoxifen, which target estrogen receptors on tumors, can dramatically reduce the risk of cancer recurring in the breast — and so you may not have to remove as much breast tissue. As we incorporate more of that sort of information and understand it from a surgical perspective, we'll be able to tailor the intensity of local treatment (surgery and radiation) more precisely. This is the next big frontier in breast cancer surgery.

Being back at Memorial as Chief of the Breast Service has been a pleasure. In returning, I was attracted by the Center's unique opportunities. We treat more breast cancer patients than any other center in the nation, and Memorial Sloan Kettering has all the resources necessary to be at the cutting edge of developing new treatments. I came here with the goal of taking full advantage of the wealth of expertise and assets to address important issues in breast cancer and patient care.

Advances in breast cancer surgery are very much based on evidence from clinical trials. So, while we continue our contributions to nationwide surgical clinical trials, we also need to more aggressively pursue our own trials to address issues important for patients at Memorial Sloan Kettering. The sentinel node biopsy story is a great example of something that did not begin here at Memorial, but in which Memorial Sloan Kettering surgeons took a lead role to answer important questions about the clinical applications of sentinel lymph node biopsy in the treatment of breast cancer. We need to be doing more of this kind of work.

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Monica Morrow
Breast Surgical Service Chief

Memorial Sloan Kettering offers a very good environment for collaborations, and we have a number of them going on. For example, in collaboration with surgeons on the Plastic and Reconstructive Surgical Service, the Breast Service is developing tools for measuring patient-reported outcomes, such as quality of life, in women who have undergone breast-conserving surgery. Plastic surgeon Andrea Pusic has developed a very nice tool for assessing quality of life in patients who have undergone breast reconstruction, but no such tool exists for assessing outcomes in women who have undergone breast-conserving surgery. So, in collaboration with Dr. Pusic and our radiation oncology colleagues, we're looking at that.

Together with members of our Clinical Genetics and Breast Cancer Medicine Services, we're examining how cancer risk can be predicted in those patients who do not have mutations in *BRCA* genes, which are common mutations in inherited breast cancer. And [breast surgeon] Kimberly Van Zee is working with the Department of Radiology on a study looking at the use of MRI in women with a very early form of breast cancer called ductal carcinoma in situ (DCIS). They are trying to see how often MRI can find other areas of cancer in women with one area of DCIS, and to determine how having the MRI test may affect their treatment.

I also want to expand our efforts in translational research, the goal of which is to apply laboratory discoveries to the surgical treatments we employ. Breast surgeon Tari King is collaborating with the Department of Pathology to study the molecular mechanisms that may cause lobular carcinoma in situ (LCIS) to progress to invasive breast cancer.

LCIS is a condition caused by changes in cells that line the lobules of the breast. By analyzing tumor samples, Dr. King hopes to discover changes that may help us predict which patients with LCIS are at high risk of developing invasive cancer. My goal is that more of our surgeons will engage in laboratory research relevant to surgery.

One of my own research interests is trying to understand how patients make decisions. For example, in collaboration with researchers at the University of Michigan, I am using national patient databases to study how women with breast cancer make treatment choices. One of the things we've found is that the greater a patient's involvement in her own treatment decision making, the more likely she is to have a mastectomy (surgical removal of the breast).

This is particularly relevant because in the United States the rates of mastectomy are rising — even though for years now breast-conserving therapy has been established as a safe option for many patients. For a long time, it was thought this was the fault of surgeons simply not offering women breast

conservation as an option. But it turns out that's not true.

Our studies show that patients are choosing mastectomy — in spite of the fact that they're being given medical information that less-radical surgery is safe and effective. We're now going to look at women with cancer in one breast who opt to have the opposite breast removed as preventive surgery.

This is another procedure that is increasing dramatically, and we want to see if we can begin to understand — from the woman's perspective — why more of them are choosing this option, especially at a time when adjuvant therapies have made the risk of developing a contralateral breast cancer lower than it's ever been. And all of this opens the door to looking at communication interventions and asking the question: Are there other, or different, ways to make medical messages more clearly heard?

My vision for the Breast Service is that it will continue its history of leadership and relevance in addressing significant clinical issues. I feel fortunate to be working with a great group of colleagues who share my interests and with whom I can share projects and ideas — and sometimes argue. I find that a bit of controversy is fun. It makes life interesting!

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