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1.0 Pathway Overview

PRIMARY CARE

All patients with lesions suspected of being breast cancer should be referred to the urgent breast cancer clinic

- Of any age with a discrete, hard lump with fixation, with or without skin tethering
- Female, aged 30 and older with a discrete lump that persists after their next period, or presents after menopause
- Female, of any age:
  (a) with a lump that enlarges
  (b) a discrete, hard lump with fixation +/- skin tethering
  (c) in whom there are other reasons for concern such as family history
- Previous history of breast cancer, who present with a further lump or suspicious symptoms
- With unilateral eczematous skin or nipple change that does not respond to topical treatment
- Unilateral blood stained nipple discharge
- Recent nipple retraction (<3 months)
- Skin distortion
- Who are male, aged 50 and older with a unilateral, firm subareolar mass with or without nipple discharge or associated skin changes

SECONDARY CARE

Other Referral e.g. screening with "en-route" examination +/- FNA +/- Core Bx

Benign Pathology
- Reassure
- Treat according

Breast Clinic
- History
- Physical examination
- Imaging
- +/- FNA
- +/- Core Bx (see text)

Malignant Pathology

Invasive Breast Cancer

Ductal Carcinoma In-situ

Surgery
- Adjuvant Rx
- Neo-adjuvant Rx

Invasive Breast Cancer

Advanced Metastatic Breast Cancer

Oncology
- Palliation (which may include)
  - Surgery
  - Endocrine Rx
  - ChemoRx
  - SPC

Appropriate Primary, Secondary Tertiary Care Support
2.0 GP Referral

PATIENT PRESENTS WITH

- Discrete, hard lump with fixation, with or without skin tethering
- Age 30 years or over with a discrete mass persisting after next period or presenting after the menopause, or with an unexplained lump in the axilla
- Any of the following:
  - Spontaneous unilateral blood stained nipple discharge
  - Unilateral eczematous skin or nipple change not responding to treatment
  - Nipple retraction (<3 months)
  - Previous histologically confirmed breast cancer, plus lump or suspicious symptoms
  - Skin distortion

- Any Age
  - Benign lumps (e.g. fibroadenoma) or breast pain and no palpable abnormality – non-urgent referral should be considered
  - Lump that enlarges, or is fixed and hard, or reason for concern such as family history

URGENT REFERRAL

- Men aged 50 years or over with unilateral, firm subareolar mass with or without nipple distortion or associated skin changes
3.0 Referral guidelines and process

GPs and other referrers are asked to refer urgently the following categories of patient:

- Who are female, aged 30 and older with a discrete lump that persists after their next period, or presents after menopause. When referring women under 30 years of age GPs should provide, on the proforma, the date of initial presentation with a lump and the date of the second consultation which should take place after the period following the initial presentation.
- Aged 30 or over with an unexplained lump in the axilla
- Of any age with a discrete, hard lump with fixation, with or without skin tethering
- Who are female, of any age:
  - With a lump that enlarges
  - With a lump that is fixed and hard +/- skin tethering
  - In whom there are other concerns such as family history
- Of any age, with previous breast cancer, who present with a lump or suspicious symptoms
- With unilateral eczematous skin or nipple changes that does not respond to topical treatment
- With nipple distortion of recent onset (<3 months)
- Skin distortion
- With spontaneous unilateral nipple discharge
- Who are male, aged 50 years and older with a unilateral, firm subareolar mass with or without nipple distortion or associated skin changes

Referrals marked urgent and suspicious of breast cancer will be seen in a clinic with Triple Assessment facilities.

Other conditions that require referral but not urgently include:

- Asymmetrical nodularity that persists at review after menstruation
- Persistent or refilling or recurrent cyst
- Pain: refer only if the patient has persistent symptoms and has failed to respond to simple measures
- Age <50 with bilateral nipple discharge sufficient to stain clothing
- Age >50 with any nipple discharge

Screening detected cancers should be referred to the appropriate breast MDT as a matter of urgency.

These referrals will be seen as soon as possible. All women with breast disease (malignant/benign) are seen within 2 weeks of receipt of referral.

Further details on the referral criteria and method of referral including fax numbers can be found on the Breast Clinic Referral Pro-forma.
4.0 Pregnancy in Breast Cancer

General Principles:

- Most pregnant women discover primary breast cancer or its advanced presentation once they have embarked on a WANTED pregnancy. Very few become pregnant having recently received these diagnoses.

- Pregnant women may wish to terminate a pregnancy under the grounds of the Abortion Act. The fetus has no legal rights until birth. Obstetricians should be informed to discuss these difficult situations with the patient.

- The outcome of Montgomery v Lanarkshire Health Board should guide the information given to pregnant women in this scenario [https://www.supremecourt.uk/cases/uksc-2013-0136.html](https://www.supremecourt.uk/cases/uksc-2013-0136.html)

- In each speciality the risks to both fetus and mother in each trimester need to be identified and information given accordingly e.g. the risks of delay of breast cancer treatment for the mother because of the pregnancy and the risk of breast cancer treatment for the fetus.

- Most studies into fetal outcome reveal that this relates to premature delivery and not the medical interventions during pregnancy and in general delivery should not normally occur before at least 32 weeks gestation.

- Breast Cancer Care booklet on this topic should be offered to all patients.

- MDM discussion is recommended using the summary guidance below - section 4.1. Due to the rarity of this situation the leads listed below should be consulted where possible. It will be their responsibility to liaise where appropriate, with other local/ regional/ national bodies to guide best practice.

- The leads for specific areas of care in pregnancy are as follows:
  - Radiology = Dr Pippa Mills Maidstone Hospital
  - Obstetrics= Ms Margaret Matthews, Maidstone Hospital
  - Neonatal paediatrics = Dr Mithuna Urs, Maidstone Hospital
  - Surgery = Ms Depeeka Akolekar, Maidstone Hospital
  - Anaesthetics = Mr Robert Horsely, Maidstone Hospital
  - Oncology = Dr Catherine Harper-Wynne, Maidstone Hospital
## 4.1 Summary

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Anaesthetics</th>
<th>Radiology</th>
<th>Oncology</th>
<th>Obstetrics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st Trimester</strong></td>
<td>Can operate</td>
<td>Avoid if possible re risk to fetus of congenital abs during organogenesis -Potential risk of miscarriage</td>
<td>Limited staging- CXR, CT chest/liver are OK</td>
<td>Not recommended either chemo or RT</td>
</tr>
<tr>
<td>Mastectomy preferred over BCS re delay of RT until after delivery.</td>
<td></td>
<td>Liver US OK</td>
<td>Biological agents not recommended at any stage of pregnancy</td>
<td></td>
</tr>
<tr>
<td>Full discussion required.</td>
<td>Bone scan, CT pelvis and PET/CT best avoided</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reconstruction not recommended</td>
<td>Full breast imaging i.e. mammogram and US OK</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **2nd Trimester** | Can operate options; - neo-adjuvant chemotherapy and then BCS followed by RT - surgery followed by chemotherapy | Can use and lowest risk to fetus and mother | AS ABOVE | Chemo can be utilized; AVOID CMF (Cyclophosphamide, methotrexate, 5-Flourouracil ) Taxanes can now be considered. Adjuvant RT not recommended | As across will monitor closely |
| | | | | | |

| **3rd Trimester** | Can perform but with limitations. Surgery with RT after delivery AXILLARY STAGING ALL TRIMESTERS | Can use but increasing risk for mother compared to 2nd. Consider delivery before surgery. | AS ABOVE | Chemo can be used up to 35 weeks. Adjuvant RT not recommended | Will closely monitor aim to deliver after 32 weeks with any increased provision needed for fetus. |
| | Radioactive isotope can be used safely in all trimesters but blue dye should not be used due to unknown effects on fetus. If SNB is positive ANC is recommended. | | | | |

RT = Radiotherapy BCS = Breast Conserving Surgery ANC = Axillary Node Clearance
5.0  Local Specialist Breast Clinic

All patients referred with breast disease should be seen in a specialist breast clinic. All staff in the clinic should be specialists in breast disease within their own field.

All patients should be offered triple assessment when appropriate. A One Stop Clinic comprising clinical examination, imaging and fine needle aspiration and/or core biopsy should be offered at the first visit. Both mammography and breast ultrasound should also be available.

The majority of patients with benign disease can be discharged after the first appointment. Patients with suspicious and/or indeterminate clinical findings or imaging will need to return to a results clinic once pathology has been completed. A counselling or quiet room should also be available.

Notes: Details of MDT structure and contacts, terms reference and membership can be found in the Breast High Level Operational Policy by following the links:
http://kmcc.nhs.uk/tumour-sites/terms-of-reference/
http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/breast-tssg/

5.0  Results Clinic

This is the clinic at which patients who have had needle biopsy of the breast or surgical treatment are told of the results of the procedure. This may be incorporated into the new patient’s breast clinic or may be a stand-alone clinic. Staff needed for this his clinic include:

- Breast surgeon
- +/- Breast clinician
- Breast Care Nurse Specialist
- Access to oncologist

Patients requiring surgery should go home with a planned date for that surgery whenever possible. Women requiring mastectomy should always be considered for reconstruction preferably immediate reconstruction if technically possible and oncologically appropriate.

6.0  Staging

Staging will be in accordance with the guidelines set out in the February 2009 NICE documents outlining the diagnosis and treatment for “Advanced Breast Cancer” and “Early and Locally Advanced Breast Cancer”

6.1  Advanced Breast Cancer

Notes: Access to “Advanced Breast Cancer” can be achieved by following the link:
http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/breast-tssg/

6.2  Early and Locally Advanced Breast Cancer

Notes: Access to “Early and Locally Advanced Breast Cancer” can be achieved by following the link:
http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/breast-tssg/
7.0 Imaging

Imaging guidelines for breast cancer can be located in the KMCC agreed document located on the KMCC website on the following link: http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/

8.0 Pathology

All KMCC reporting pathologists follow The Royal College of Pathologists Histopathology Reporting on Cancers guidelines – a copy of which is available through the KMCC website:- http://kmcc.nhs.uk/tumour-sites/sub-groups-or-cross-cutting-groups/

For Guidelines for pathology reporting in breast disease please see:- http://www.cancerscreening.nhs.uk/breastscreen/publications/nhsbsp58.html

9.0 Surgical Provision

9.1 Invasive or In-situ Carcinoma

Following histological confirmation of malignancy (always by core biopsy) the treatment options should be considered by the Multidisciplinary Team (MDT) in the light of:

- The clinical findings
- The mammographic & ultrasound appearance
- The tumour size
- The tumour grade
- The clinical/ultrasound node status
- The patient's age and performance status
- Patient choice/preference

Multifocality, extensive microcalcification & infiltrating lobular carcinoma are risk factors for incomplete resection margins following conservative surgery.

MRI scans may be offered for patients with Invasive Lobular Carcinoma (ILC).

The options should then be discussed with the patient which may include:

- Primary conservative surgery
- Primary mastectomy + reconstruction, immediate or delayed
- The extent and morbidity of axillary surgery
- Neo-adjuvant chemo/RT/hormone therapy
- Salvage surgery for residual or recurrent disease

If conservative surgery is a reasonable option the following risks should be discussed:

- That incomplete resection will indicate subsequent further surgery.

(The patient should be reassured she will not have a primary mastectomy without specific consent).

- The need for post-operative radiotherapy
- Volume loss and suboptimal cosmetic outcome
- The morbidity of proposed axillary surgery

If Mastectomy – is the clinical recommendation or the patient’s choice:
The options for reconstruction should be considered in detail with the surgeon and (separately) with the breast care nurse. If the patient opts to see a plastic surgeon with a view to a free Transverse Rectus Abdominus Myocutaneous (TRAM) or Deep Inferior Epigastric Perforator (DIEP) flap, this should be arranged urgently.

The options for Reconstruction include:
- Tissue expander or Gel-filled implant
- Subcutaneous mastectomy with implant + nipple preservation
- Latissimus dorsi flap + implant
- Pedicle TRAM flap (autologous)
- Free TRAM/DIEP flap (autologous)
- Nipple reconstruction and tattooing
- Adjustment to the contralateral breast
- Free buttock flap
- TUG flap

The patient may be shown examples. It is important that the risks of a poor cosmetic outcome are explained and clearly documented. The complications of loss of implant/flap and fat necrosis etc. should be stated.
- BAPRAS/BASO guidance to be followed for implants fit for fat transfer.
- The indication for post op Radiotherapy will depend on the node status/grade.
- If post-operative Radiotherapy is recommended the cosmetic outcome after immediate reconstruction may be compromised. (Radiotherapy reduces Local Recurrence by 2/3).
- For patients who are not symptomatic and there is no indication of metastases, surgery would proceed without staging; if metastases are indicated, then staging should be completed before reconstruction takes place.
- The offer of delayed breast reconstruction is usually made to patients at the outset of the cancer pathway when planning surgical treatment. However, some patients decline delayed breast reconstruction initially and change their minds later. This is acceptable and delayed reconstruction can still be offered.

Nurse consultation
There should be the opportunity for a separate consultation with a breast care nurse specialist in a protected environment.

This is an opportunity to:
- Discuss and clarify treatment options
- Provide personal and family support
- Assess psychological coping mechanisms and screen for risk factors for depression/anxiety
- Provide information in multimedia formats
- Provide contact details for local and national support organisations

9.2 Conservative Surgery

Impalpable tumours will require pre-operative ultrasound or stereotactic localisation.
- Normally a skin ellipse (minimal) overlying the tumour will be excised though this may not be appropriate for a wire-guided procedure.
- Wide local excision of the tumour will normally be taken down to fascia. (This may not be considered necessary if the tumour is very superficial – in which case the deep resection margin should be histologically clear – 1mm or more)
- Macroscopically should be complete
- Specimen radiology is recommended
- Tumour bed/quadrant biopsies of the residual cavity may be carried out – by local protocol
9.3 Axillary nodes

- Sentinel Node Biopsy (SNB) is the preferred option for patients with “normal” axillae.
- Patients with positive SNB should proceed to further axillary surgery.
- Axillary clearance should be considered if the nodes are radiographically or cytologically positive.
- Axillary dissection may be more appropriate for some patients.

Patients will be discussed on an individual basis at MDT as the majority will not require further surgery. Those that could be offered surgery will be given the opportunity to discuss options further with a consultant.

9.4 Resection margins – invasive disease

- Resection margins are a controversial issue in the absence of outcome data but
- It is suggested that further surgery be recommended to the patient if the radial resection margin for invasive carcinoma is <1 mm
- or if a quadrant/tumour bed biopsy is positive for invasive or in situ disease
- If further surgery is recommended the options lie between a re-excision of the involved margin or a mastectomy + reconstruction.

9.5 Ductal Carcinoma In-situ (DCIS)

- DCIS – a clearance margin > 2 mm is recommended especially with High grade tumours
- If DCIS extends to > 40 mm or is multifocal - mastectomy should be considered.
- Node sample in pure DCIS is not recommended; unless there is a significant chance that invasive disease will be found on the final histology. This is a clinical decision. SNB can be done during mastectomy for DCIS due to their proximity to the axillary tail of the breast. SNB may be considered for patients with extensive DCIS.

9.6 Post Primary Surgery

- The pathological findings of the resected specimen should be considered by the MDT – in particular.
- A close or involved radial resection margin will normally indicate the need for further surgery.
- A Positive node sample indicates the need for an axillary clearance or post operative radiotherapy.

The recommendations for adjuvant chemotherapy/radiotherapy/hormone therapy and subsequent follow-up should be agreed at that meeting.

9.7 “Marker” Clips

- Clips should be inserted into the tumour bed at the time of surgery to aid planning; at least 5 clips should be inserted
9.8 Post surgery hormone treatment

- Surgeons are asked not to commence hormone therapy post operatively but to wait for oncologists to commence this post radiotherapy

10.0 Oncology Provision

Oncology Guidelines are agreed by the Breast NOG (Non-Surgical Oncology Group) on behalf of the TSSG. The guidelines include:

- Adjuvant chemotherapy
- Adjuvant hormone therapy (for hormone receptor positive patients, ER and/or PgR)
- Adjuvant Trastuzumab
- Post-operative radiotherapy
- Neoadjuvant chemotherapy
- Neoadjuvant endocrine therapy
- Endocrine treatment in advanced disease
- Chemotherapy in advanced disease
- Bisphosphonates for bone metastases
- Use of antibiotics and GCSF
- Management of DCIS
- Management of Male Breast Cancer
- Use of the Mirena coil in patients with oestrogen receptor positive tumours
- Assessment of bone loss
- KMCC guidelines on managing cardiac toxicity for patients receiving adjuvant trastuzumab
- Bisphosphonate guidelines incorporating prescribing in renal impairment

Notes: Access to the full Oncology Guidance can be achieved by following the link:
http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/breast-tssg/

11.0 Treatment of Liver Metastases

- Patients with liver metastases can be referred to King’s College Hospital hepatobiliary surgeons for surgical resection, if suitable. Certain criteria must be fulfilled: eg. single lobe affected and resectable, as defined by them. A pro-forma must be filled in and sent through to King’s Liver Unit for referral. [HPB Referral form - King’s College Hospital NHS Foundation Trust](http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/breast-tssg/)
- Selective Internal Radiation Therapy (SIRT) for primary or secondary liver tumours is available at King’s. The SIRT working group agreed that current evidence supports the use of SIRT. However, this is relatively new and requires special funding. The TSSG therefore agreed not to support SIRT for all cases and rather to be used on case specific basis.
12.0 Follow Up

12.1 Imaging Recommendations

- Offer annual mammography to all patients with early breast cancer, including DCIS, until they enter the NHSBSP/BTWSP. Patients diagnosed with early breast cancer who are already eligible for screening should have annual mammography for 5 years.
- On reaching the NHSBSP/BTWSP screening age or after 5 years of annual mammography follow up, we recommend the NHSBSP/BTWSP stratify screening frequency in line with patient risk category.
- Do not offer mammography of the ipsilateral soft tissue after mastectomy.
- Do not offer ultrasound of MRI for routine post-treatment surveillance in patients who have been treated for early invasive breast cancer or DCIS.

12.2 Clinical Follow Up Recommendations

- After completion of adjuvant treatment (including chemotherapy and/or radiotherapy where indicated) for early breast cancer, discuss with patients where they would like follow up to be undertaken. There is no robust evidence that follow up in any specific setting reduces the rate of recurrence or improves survival. Some patients may gain considerable reassurance from being reviewed in a specialist setting with healthcare professionals who have been responsible for their care from the beginning. Studies have shown no difference in outcome of patients followed up in GP practice or in the hospital setting. Patients should be given the information and support they need if they want to consider opting out of follow up care. It is important that choice, as with other treatment decisions, is explored and patient preferences respected.
- Patients treated for breast cancer should have an agreed, written care plan, which should be recorded by a named healthcare professional (or professionals), a copy sent to the GP and a personal copy given to the patient. This plan should include:
  - Designated named healthcare professionals
  - Dates for review of any adjuvant therapy
  - Details of surveillance mammography
  - Signs and symptoms to look for and seek advice on
  - Contact detailed for immediate referral to specialist care and
  - Contact details for support services, for example support for patients with lymphoedema

(Based on NICE ‘Recommendation for Early and Locally Advanced Breast Cancer Follow Up - February 2009.’)

13.0 Supportive and Palliative Care

The General Practitioner should be informed within 24 hours of the initial diagnosis, treatment planning and medication planning decisions, and thereafter within 24 hours of any reviews, particularly when there are any changes in management.

The management of symptoms, psychological, social and spiritual issues, the communication of the diagnosis, and any associated problems, should be within the domain of all health care professionals.

Open and frank discussions with patients should take place at all stages of their journey so that patients are not confused about their prognosis or have unrealistic expectations of any of the forms of treatment offered to them.

Relatives and carers will need to be appropriately supported and given appropriate information. However, in accordance with the recommendations set out in various revised Improving Outcomes Guidance, relatives and carers should not be given information different to that given to the patient.

Supportive and palliative care should be provided by all health care professionals involved with a patient including:
Site specific cancer clinical nurse specialists
Cancer services social workers
Members of primary health care teams
Ward and outpatient nursing and medical staff

Referral to specialist palliative care services should be considered when these issues have not been resolved and in particular for patients with:
- Complex physical needs and/or complex psychosocial and spiritual needs, but ONLY when these are particularly difficult to manage

Consideration of specialist palliative care or support should be given throughout the patient pathway, particularly:
- At the Multidisciplinary Team Meeting
- When no active treatment is considered
- After active treatment
- At relapse
- In the terminal stages

14.0 Data

Collection of data at each stage of the pathway is the responsibility of the team looking after the patient at that time. The minimum dataset agreed by the TSSG will be a combination of those data items that meet national requirements, and additional items as agreed by the TSSG.

National data requirements will include:
- Cancer Waiting Times monitoring, including Going Further on Cancer Waits. The data items required will be as defined in ISB0147 at the time of referral and/or treatment.
  
  
  Cancer Waiting Times data will be submitted according to the timetable set out in the National Contract for Acute Services.
  
- The Cancer Outcomes and Services Dataset. The data items will be as defined in ISB1521, and any subsequent versions, at the time of diagnosis and/or treatment. The requirement will include those fields listed in the “Core” section of the dataset, and any additional tumour site specific sections, as applicable.
  
  
  Cancer Registration and Cancer Outcomes and Services (COSD) data will be submitted according to the timetable set out by National Cancer Registration Service.
  
- Where applicable, teams will also collect additional data items as defined in any corresponding National Clinical Audit Support Programme (NCASP) audit dataset.
  
  Details of these datasets are available from: [http://www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/cancer](http://www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/cancer)
  
  Data for NCASP audits will be submitted, where applicable, according to timetables as agreed by the TSSG, and within the overall submission deadlines for each audit.

Submission of data to meet these national requirements will be the responsibility of each individual Trust.

Note that these standards are subject to variation from time to time, and where these requirements change, the data items required to be collected by the team will also change in line with national requirements.
Local data requirements will include any additional data items as agreed by the TSSG. These must be selected to avoid overlap with any existing data items, and where possible must use standard coding as defined in the NHS Data Dictionary.

Where possible and applicable, InfoFlex will be used for the collection and storage of data.

Additional areas of the COSD, relating to pathology, radiotherapy, SACT, diagnostic imaging and basic procedure details will feed into the dataset from other nationally mandated sources. It is the responsibility of each team to ensure that the whole of the relevant dataset is collected, and it is acknowledged that this may come from a variety of sources.
15.0 Appendix 1

GUIDANCE FOR THE ADJUVANT USE OF AROMATASE INHIBITORS
(KMCC Breast and Follow-Up TSSG Sub-groups)

NICE have recommended that all hormone receptor positive post menopausal women are considered for an aromatase inhibitor (AI) at some stage in their adjuvant treatment. This document accompanies the guidance given in KMCC BREAST CANCER PATHWAY: Oncology guidance.

A1 Aromatase Inhibitors (AI) can be given:

1. Immediately following surgery or chemotherapy – “up front or initial therapy” for 5 years. This is discussed at MDM and final decision made at first oncology out-patients.
2. After 2-3 years of Tamoxifen – “unplanned switch” for 2–3 years to complete 5 yrs of treatment. Planned switch is also being adopted i.e. discussed prospectively at MDM and clearly indicated in patients notes.
3. After 5 years of Tamoxifen in node +ve patients – “extended adjuvant” for 5 years

A2 Situation at present

1. There is no clear cut evidence as to whether ‘initial’ or ‘switch’ is preferential. This will be concluded with the publication of the BIG -198 trial.
2. The KMCC policy at present is to use an Aromatase Inhibitors (AI) up front in patients known to be high risk of early relapse (clinical discretion). Licensed drugs are ARIMIDEX (1mg od) & LETROZOLE (2.5mg od)
3. Patients being seen at 2 or 3 years on Tamoxifen in clinics should be offered to switch at that time. Licensed drugs are EXEMESTANE (25mg od) and ARIMIDEX.
4. Patients who are past 3 years and tolerating Tamoxifen well should stay on Tamoxifen for the planned 5 years.
5. If they are node + they should be offered extended adjuvant Letrozole at the end of 5 years.
6. It would seem reasonable for those women who responded well to Letrozole neo-adjuvantly to continue it post-operatively.

AIs’ are only licensed in post menopausal women. When given premenopausally they cause heavy vaginal bleeding and can even induce ovulation and thus pregnancy. It is mandatory for women under 56 to check the FSH at least (and preferably LH as well – oestradiol is unhelpful in the presence of Tamoxifen); FSH should be at least 35 with amenorrhoea for at least a year. Take advice from local laboratories. There is no good data on how to reliably define the menopause in our patients; particular care should be taken in young women post chemotherapy in whom ovarian function can recover even after 2 years, despite amenorrhoea. These women should not be put onto an AI as initial or switch therapy (refer to KMCC Breast Cancer Pathway).

A3 Management of side-effects from Aromatose Inhibitors (AI)

1. The side effects of AIs’ that are more common than Tamoxifen are arthralgia and osteoporosis. Glucosamine may help the arthralgia. Patients who can’t tolerate AIs’ can go back to Tamoxifen.
2. All patients on adjuvant AIs’ should have a bone density scan booked at the beginning of treatment and this is the responsibility of the initiating physician.
3. For MTW and Medway if the planned duration of AI is stated on the form, the relevant Radiologist/Consultant will recommend whether and when a repeat scan is required.
4. If it is unclear following first DEXA result when the next scan is due, the general rule if there is no significant osteopenia is 2 years.
5. If borderline osteoporosis at any point advice should be sought from the local osteoporosis specialist. AIs’ can often still be given following advice with bisphosphonates and calcium supplementation.
6. As trials have reported increase in cardiac events and lipids, patients should report any new cardiac events whilst on an AI and medical advice sought if concerned at starting or continuing an AI.

Oncologists are available to aid in the medical management of AIs’.
16.0 Personnel and Contact Information

A comprehensive, up to date list of MDM contact details can be found on the KMCC website via the following link: http://kmcc.nhs.uk/tumour-sites/terms-of-reference/

17.0 Glossary

Acronyms in common usage throughout KMCC documentation:

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI</td>
<td>Aromatase Inhibitor</td>
</tr>
<tr>
<td>DCIS</td>
<td>Ductal Carcinoma In-situ</td>
</tr>
<tr>
<td>CNB</td>
<td>Cancer Network Board</td>
</tr>
<tr>
<td>CYP</td>
<td>Children &amp; Young People (in relation to the IOG)</td>
</tr>
<tr>
<td>DCCAG</td>
<td>Diagnostic Cross Cutting Advisory Group</td>
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<td>DOG</td>
<td>Disease Orientated Group (NSSG/TSSG/TWG)</td>
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<td>DVH</td>
<td>Darent Valley Hospital</td>
</tr>
<tr>
<td>EK</td>
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<tr>
<td>EKHFU</td>
<td>East Kent Hospitals University Foundation Trust</td>
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<tr>
<td>HoP</td>
<td>High Level Operational Policy</td>
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<tr>
<td>IOSC</td>
<td>Improving Outcomes: A Strategy for Cancer</td>
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<tr>
<td>K&amp;C</td>
<td>Kent &amp; Canterbury Hospital, Canterbury, (EKHFUFT)</td>
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<td>KMCC</td>
<td>Kent &amp; Medway Cancer Collaborative</td>
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<tr>
<td>KMCN</td>
<td>Kent &amp; Medway Cancer Network</td>
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<tr>
<td>KMCRN</td>
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<tr>
<td>LSESN</td>
<td>London &amp; South East Sarcoma Network</td>
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<tr>
<td>MFT</td>
<td>Medway Foundation Trust</td>
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<tr>
<td>MTW</td>
<td>Maidstone &amp; Tunbridge Wells NHS Trust</td>
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<tr>
<td>NOG</td>
<td>Non Surgical Oncology Group (Permanent oncologist sub group of the TSSGs with a specific responsibility for chemo/rad pathways and advice to the TSSG, KMCC and geographical locations on new drugs)</td>
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<td>PoC</td>
<td>Pathway of Care (KMCC agreed disease site specific clinical guidelines)</td>
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<td>QEOM</td>
<td>Queen Elizabeth the Queen Mother Hospital, Margate (EKHFUFT)</td>
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<td>QoL</td>
<td>Quality of life</td>
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<td>RMH</td>
<td>Royal Marsden Hospital</td>
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<td>RNOH</td>
<td>Royal National Orthopaedic Hospital</td>
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<td>Queen Victoria Foundation Trust Hospital East Grinstead</td>
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<td>TSSG</td>
<td>Tumour Site Specific Group</td>
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<td>TYA</td>
<td>Teenage &amp; Young Adults</td>
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<td>UCLH</td>
<td>University College Hospital London</td>
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<td>WHH</td>
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<td>WK</td>
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# 18.0 Document Administration

<table>
<thead>
<tr>
<th>Document Title</th>
<th>The Management of Breast Cancer – Pathway of Care</th>
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<tbody>
<tr>
<td>Principle author</td>
<td>Delilah Hassanally</td>
</tr>
<tr>
<td>Co-author(s)</td>
<td>Ian Vousden/Caroline Tsatsaklas/ C.Harper-Wynne/N.Aluwalia/TSSG members</td>
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<tr>
<td>Current version number</td>
<td>6.2</td>
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<tr>
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<td>Original publication date</td>
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<tr>
<th>Enquiries:</th>
<th>[1] Haresh Devalia</th>
<th><a href="mailto:haresh.devalia@nhs.net">haresh.devalia@nhs.net</a></th>
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<tr>
<td></td>
<td>[2] Natalie Aluwalia</td>
<td><a href="mailto:natalie.aluwalia@nhs.net">natalie.aluwalia@nhs.net</a></td>
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## Revision History

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<tr>
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<th>New Version Number</th>
<th>Nature of Revision</th>
<th>Confirmation of Accuracy by</th>
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<tr>
<td>Sept 2005</td>
<td>0.1</td>
<td>Initial draft – all sections reviewed &amp; new flow chart</td>
<td>A.Jackson</td>
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<tr>
<td>Sept 2005</td>
<td>0.2</td>
<td>2nd draft – follow up revisions</td>
<td>R.Toye/J.Weeks</td>
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<td>Jan 2006</td>
<td>0.3</td>
<td>3rd draft – updated version from collated comments since Dec 2005 DOG</td>
<td>A.Jackson</td>
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<tr>
<td>Feb 2006</td>
<td>0.4</td>
<td>4th draft – revised oncology section and updates from email comments on 3rd draft</td>
<td>C.Harper-Wynne/ A.Jackson/ S.Green</td>
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<td>Feb 2006</td>
<td>1.0</td>
<td>Published final (final amendments agreed DOG 6/2/2006)</td>
<td>A.Jackson</td>
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<tr>
<td>Feb 2008</td>
<td>1.1</td>
<td>Draft revision – amendments to oncology section</td>
<td>A.Jackson / C.Abson</td>
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<tr>
<td>May 2008</td>
<td>1.2</td>
<td>Interim PoC – changes to pages 11 &amp; 12 following email from C.Abson</td>
<td>A.Jackson / C.Abson</td>
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<td>May 2009</td>
<td>1.3</td>
<td>Draft revision – GP flow chart by Primary Care Group inserted; Market clips to tumour bed; Hormone Rx post Sx; Process section deleted and transferred to the HOP; Contacts deleted and transferred to Contacts Directory; Links to imaging, oncology and NICE inserted</td>
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<td>R.Liebmann/ N.Williams/ C.Abson/ P.Bentley</td>
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<td>2.1</td>
<td>Draft – addition of sections Treatment of Liver Metastases and Delayed Breast Reconstruction</td>
<td>D.Hassanally</td>
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<tr>
<td>Sept 2011</td>
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<td>March 2012</td>
<td>3.1</td>
<td>Draft – put in to new format</td>
<td>L.Caine/J.Bullass</td>
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<td>June 2012</td>
<td>3.2</td>
<td>Draft – updated all weblinks inc. imaging, pathology &amp; contacts; general formatting &amp; content checking</td>
<td>C.Tsatsaklas</td>
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<td>July 2012</td>
<td>3.3</td>
<td>Draft – deletions from Oncology Provision in line with Breast NOG oncology guidelines</td>
<td>C.Waters/C.Tsatsaklas</td>
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<td>July 2012</td>
<td>3.4</td>
<td>Draft – Oncology Provision section updated</td>
<td>C.Waters/C.Tsatsaklas</td>
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<tr>
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<td>3.5</td>
<td>Draft – data collection section updated</td>
<td>A.Brittle/C.Tsatsaklas</td>
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<td>Final/Published -agreed revisions from 18/11/2012 Breast DOG included/ratified</td>
<td>Breast DOG/ I.Vousden/C.Tsatsaklas</td>
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<td>May 2014</td>
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<td>Final – updates agreed in 29/04/2014 Breast TSSG inc. removal of KMCN, DOG, replace with KMCC, TSSG etc</td>
<td>Breast TSSG/ DHassanally/ CTsatsaklas</td>
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<td>May 2015</td>
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<td>DRAFT – wording addition to section 9.3</td>
<td>Breast TSSG/</td>
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<td>June 2015</td>
<td>6.0</td>
<td>Final – Ratified by O&amp; Q Group – 22.06.15</td>
<td>N.Aluwalia</td>
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<tr>
<td>July 2017</td>
<td>6.1</td>
<td>Draft – addition of breast cancer in pregnancy protocols, amended weblinks and amended 2ww guidance according to NG12</td>
<td>N.Aluwalia</td>
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<tr>
<td>October 2017</td>
<td>6.2</td>
<td>Updated following TSSG meeting, TSSG ratified. This now needs O&amp;Q ratification prior to publishing</td>
<td>N.Aluwalia</td>
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<tr>
<td>March 2018</td>
<td>7.0</td>
<td>TSSG 20.03.18 agreed Final version</td>
<td>A.Wiltshire</td>
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