Kent and Medway Cancer Collaborative

The Management of Breast Cancer

Pathway of Care

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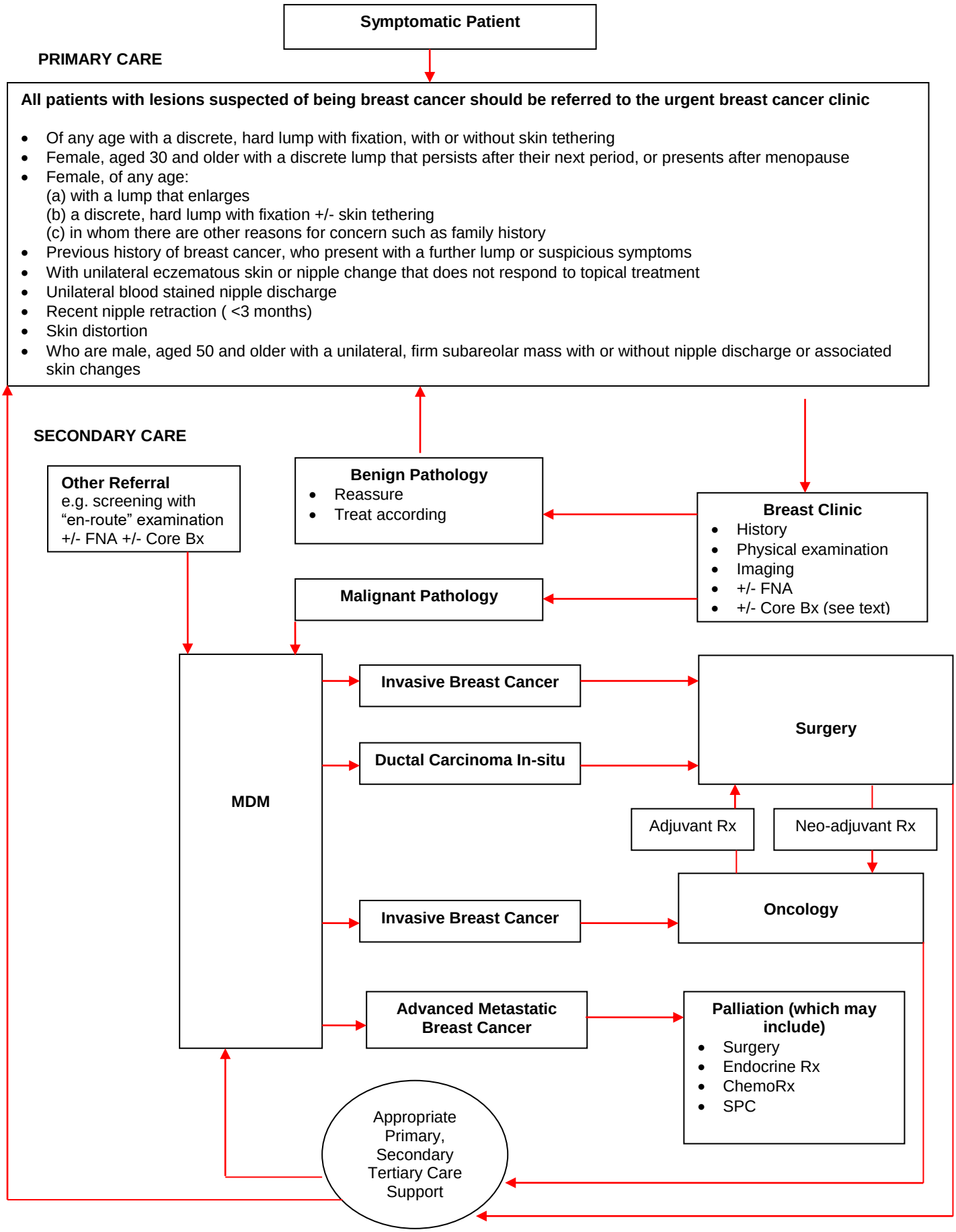
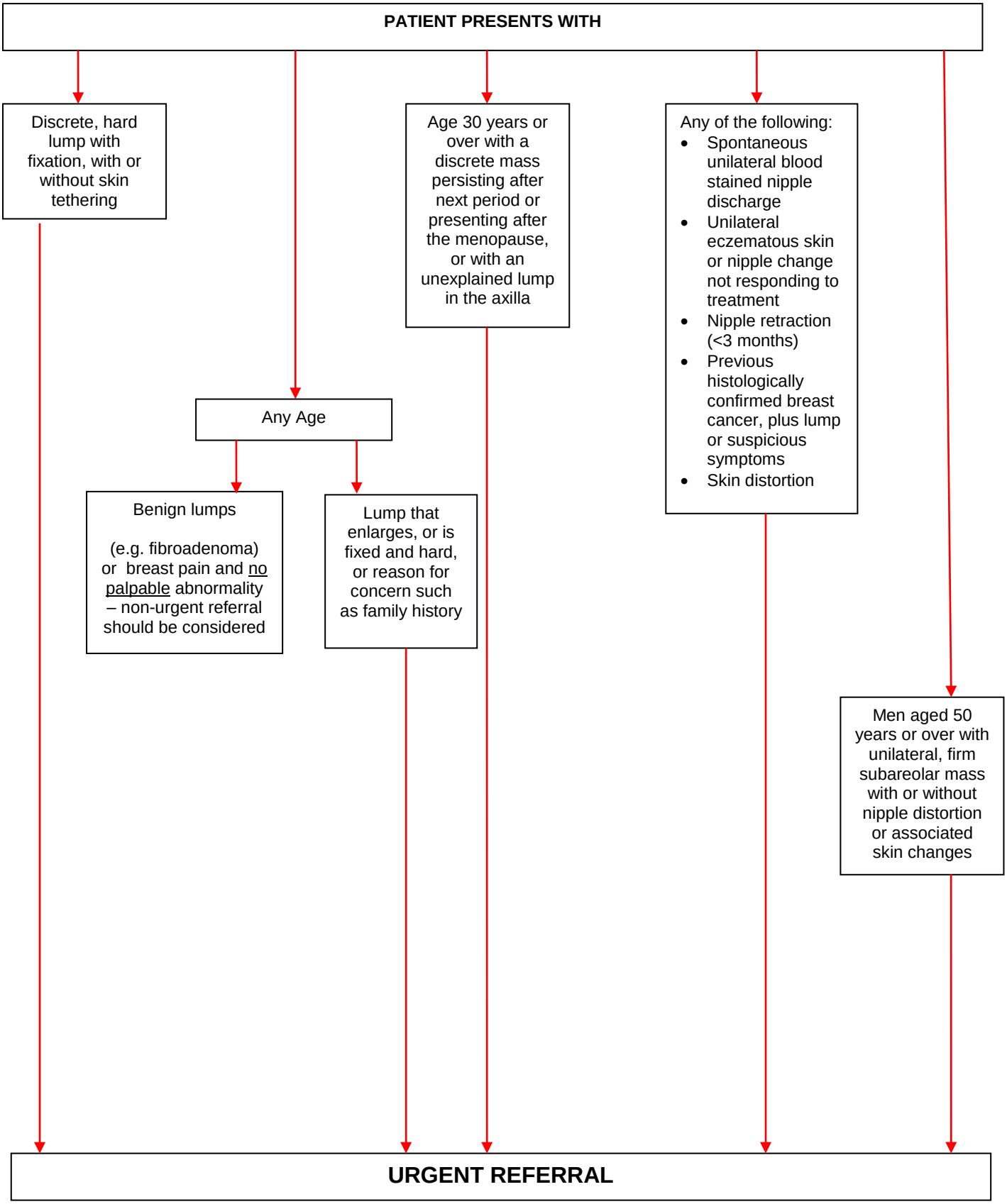
1.0 Pathway Overview



2.0 GP Referral



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 subareaolar 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.

Further information can be obtained here
http://associationofbreastsurgery.org.uk/media/424609/service-guidance-v5.pdf

4.0 Pregnancy in Breast Cancer

General Principles:

Incorporating guidance from MBRRACE-UK 2019 (Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK) and RCOG Green-top guideline 12.

- Breast Cancer Now booklet on this topic should be offered to all patients
- Women under investigation for breast cancer should be advised on contraception and postponement of pregnancy.

- Refer women using a suspected cancer pathway referral (for an appointment within 2 weeks) for breast cancer if they are aged 30 and over and have an unexplained breast lump with or without pain. Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for breast cancer in women: with skin changes that suggest breast cancer or aged 30 and over with an unexplained lump in the axilla.
- FNA for diagnosis is not recommended for diagnosis only core biopsy.

- 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 after full discussion with multi-disciplinary team. 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

- 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.

- Prednisolone should be used over Dexamethasone due to data on poorer cognitive development in fetus.

- GCSF can be used if needed but ideally not prophylactically due to lack of data

- Thromboprophylaxis should be considered and discussed with obstetrician with highest risk in 3rd trimester.

- Most studies into fetal outcome reveal that this relates to premature delivery and not the medical interventions during pregnancy. Most women should be able to go to full term and have a normal or induced birth.

- Women can be reassured that they can breastfeed from the unaffected breast. There should be a time interval of 14 days or more from the last chemotherapy session to start of breastfeeding to allow drug clearance from breastmilk. If chemotherapy is restarted, breastfeeding must cease. A short period of lactation may be psychologically beneficial after a stressful pregnancy and be beneficial to the baby

.

- At diagnosis, the impact of the cancer and its treatment on future fertility should be discussed between the woman diagnosed with cancer and her cancer team

- The risk of breast cancer recurrence is highest within the first two years after treatment. Most women with breast cancer should therefore wait at least two years after treatment before considering further pregnancy.

- 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 Nicky Dineen, Maidstone Hospital
    - Obstetrics= Ms Phillipa Moth, 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

	Surgery	Anaesthetics	Radiology	Oncology	Obstetrics
1st Trimester	Can operate Mastectomy preferred over BCS re delay of RT until after delivery. Full discussion required. Reconstruction not recommended	Avoid if possible re risk to fetus of congenital abs during organogenesis -Potential risk of miscarriage	Limited staging- CXR, CT chest/liver are OK Liver US 0K Bone scan, CT pelvis and PET/CT best avoided Full breast imaging i.e. mammogram and US OK MRI should only be used without gadoliniium	Not recommended either chemo or RT Biological agents not recommended at any stage of pregnancy	Because of the other speciality issues, termination most likely to be discussed in this trimester
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- Flurouracil) Taxanes can now be considered. Supportive agents: 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 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.	Can use but increasing risk for mother compared to 2nd. Consider delivery before surgery.	AS ABOVE	Chemo can be used throughout but with final cycle to be timed according to delivery. If diagnosed in 3rd trimester attempt to give 2 cycles of chemo pre delivery. Adjuvant RT not recommended	Will closely monitor and aim to deliver as close to term as possible with any increased provision needed for fetus.

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

Early and locally advanced breast cancer: diagnosis and management
NICE guideline [NG101] Published: 18 July 2018
https://www.nice.org.uk/guidance/ng101

ASCO Statement RW, Allred DC, Anderson BO, et al: Invasive breast cancer. J Natl Compr Canc Netw 9:136–222, 2011
American Society of Clinical Oncology
View all recommendations from this society
Released April 4, 2012
Don't perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.
- Should say 'consider radiological staging of Stage III EBC if concerning features eg> 4 positive lymph nodes after surgical resection. Should also consider staging when tumours >5cm and triple negative tumours prior to neoadjuvant. All tumours that do not respond or progress on neo-adjuvant therapy should be considered for radiological staging.

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

Guidance on screening and symptomatic breast imaging, Fourth edition

Reference: BFCR(19)9, Date:2019

https://www.rcr.ac.uk/publication/guidance-screening-and-symptomatic-breast-imaging-fourth-edition

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

Royal college of pathologists updated guidance on diagnostic biopsy

9.0 Surgical Provision

http://associationofbreastsurgery.org.uk/media/409600/breast-surgery-v9-ii.pdf

http://associationofbreastsurgery.org.uk/media/252042/cancer-surgery-v5.pdf

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 for autologous free flaps such as 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
- 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.

https://associationofbreastsurgery.org.uk/media/359061/abs-oncoplastic-guidelines-2021.pdf

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 clinically / radiologically "normal" axillae.
- Patients with positive SNB with macrometstasis may proceed to further axillary surgery.
- Axillary clearance should be considered if the nodes are positive (macrometastasis) on SNB.
- 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.

https://associationofbreastsurgery.org.uk/media/65284/axilla-following-nact-2019.pdf

Await updated guidance

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 > 1 mm is recommended especially with High grade tumours

- If DCIS is extensive or is multifocal – advanced oncoplastic surgery or 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. SNB may be considered for patients with extensive DCIS or having mastectomy.
- OSNA is not recommended in these patients.

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 RT planning; at least 5 clips should be inserted
- Apical clips should be inserted in axilla to help with radiotherapy volume.

9.8 Post surgery hormone treatment

Unless chemotherapy is planned or as specified at MDM, Surgeons should commence hormone therapy post operatively.
Where there is no requirement for post-operative radiotherapy or chemotherapy hormone treatment will be led by the surgical team. Where this is helpful tools such as NHS PREDICT and CTS5 may be used to aid endocrine duration decisions

Pre-Menopausal

- Lower Risk patient:
  - Tamoxifen for 5-10 years.
- Higher Risk patients:
  - LHRH agonist + Exemestane (or tamoxifen if poorly tolerated) for 5 years.
  - If post-menopausal after 3-5 years of tamoxifen, consider switch to AI for a further 2-5 years

Post-menopausal

- Lower risk patient
  - AI for 5 years.
  - If not tolerated or relative contraindication (e.g., osteoporosis, very high cholesterol, arthritis) then Tamoxifen for 5-10 years is reasonable.
- Higher risk patient
  - AI for seven years (ten years in very high-risk cases).

For patient's intolerant of an AI or if an AI relatively contraindicated Tamoxifen may be used for all or part of this period

- Patients should have DEXA to guide osteoprotection. This should be repeated guided by the results and duration of endocrine therapy planned as outlined in the nonsurgical oncology guidance. For those having extended endocrine therapy it would be good practice for DEXA to be repeated around year 5 even if normal at baseline
- A simple change in AI may be helpful for many patients who experience symptomatic AI toxicity
- An algorithm for lifestyle/pharmacological suggestions which may help manage vasomotor side effects is available in appendix F of the non-surgical oncology guidance http://kmcc.nhs.uk/tumour-sites/tumour-site-specific-information/breast-tssg/
- Atrophic vaginitis: Vaginal dryness that fails to respond to non-hormonal topical therapies (Sylk, Replens, Astraglide, Yes etc) can be treated with topical oestrogen creams or pessaries. Systemic 'spill over' effect is likely to be low and will probably not affect the efficacy of tamoxifen. However, this is not the case with the aromatase inhibitors where their use is relatively contraindicated.
- Atypical vaginal bleeding while on tamoxifen needs to be evaluated urgently by a gynaecologist as this may be a symptom of endometrial hyperplasia or dysplasia. The decision to continue tamoxifen after such an evaluation needs to be made in conjunction with the gynaecologist

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 Metastatic disease

General Principles

Unless there is no suitable site for biopsy, histological confirmation of metastatic disease and up-to-date receptor status (ER and HER2) should be obtained.

- The ER and the HER2 status of the metastatic tumour may be different from the primary as it can be influenced by prior therapies and clonal outgrowthUp to 9% of Non-malignant/non breast primary source explanations for the radiological change will be identified

In general patients are treated with palliative intent

In a small number of patients with oligometastatic disease and long disease-free intervals a more radical approach to the management of metastases may be appropriate. This should always be a consultant and/or MDT decision. Approaches to consider include metastatectomy, radiofrequency ablation and stereotactic radiotherapy (SABR, tomotherapy, Cyberknife, Gamma Knife). Clinical trials for this group of patients may be available.

Radical treatment of Oligo-Metastatsis

Liver

- 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

- 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.
- Radiofrequency ablation may be considered for suitable lesions <3cm^3

Brain

- Patients with limited CNS metastasis who have well controlled or absent systemic disease, performance status 1-2, and life expectancy of >6 months should be considered for neurosurgical resection and/and or stereotactic radiotherapy.

- The neurooncology referral from is available at https://www.kch.nhs.uk/service/a-z/neuro-oncology .

Lung and internal mammary node

- Patients with new limited pulmonary or isolated IMC recurrence may be suitable for metasatectomy or stereotactic body irradiation. Surgery may be the preferred choice where confirming histology is important

- Referral for surgery should be via the local lung MDM or to the KOC SABR MDM at KOC SABR MDT email: "KOC-SABRMDT (MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST)" <mtw-tr.koc-sabrmdt@nhs.net>

- Referral. in short - it's like adding an annotation. patient needs site specific MDT discussion first to make sure SABR is considered an option.
    - Go to clinical history --> Add New --> scroll down --> select ''SABR Referral From'' --> Click OK (twice) --> fill in the form --> Submit --> Pt will be discussed at SABR MDT
- treatment for oligomets currently
    - at KOC - Lung, Bone, Spine, Lymph nodes
    - at GSTT - Liver, adrenals (this will be available at KOC hopefully soon, we'll update as and when available) referral can be done via KOC ref form

- Lung function tests should ideally be requested to aid MDM discussion

Bone

- Selected patients may benefit from radical treatment with SRS or surgery (local or specialist orthopaedics)

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.)

Patients should be advised about lifestyle changes that reduce their cardiovascular and relapse risk

- Smoking cessation.
- Improving diet: – considering reduced alcohol consumption (– heavy alcohol consumption can both increase blood pressure and reduce cardiac function) – reducing dietary salt – reducing fat – increasing fruit and vegetable consumption (5-a-day).
- Increasing physical activity: – moderate intensity exercise – build up to 30 minutes 5 times a week (Department of Health guidelines).
- Weight loss where appropriate

Additional support can be accessed using information on the Breast Cancer Kent app and moving forward courses which can be accessed via the breast cancer nurses

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.

  Details of the COSD are available from:
  http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd.aspx

  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.

  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.

ABS guidance on hormone management / toxicity

Osteoporosis guidelines to be inserted.

A1 Aromatose 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

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:

AI	Aromatase Inhibitor
DCIS	Ductal Carcinoma In-situ
CYP	Children & Young People (in relation to the IOG)
DCCAG	Diagnostic Cross Cutting Advisory Group
DOG	Disease Orientated Group (NSSG/TSSG/TWG)
DVH	Darent Valley Hospital
EK	East Kent
EKHUFT	East Kent Hospitals University Foundation Trust
HoP	High Level Operational Policy
IOSC	Improving Outcomes: A Strategy for Cancer
K&C	Kent & Canterbury Hospital, Canterbury, (EKHUFT)
KMCA	Kent & Medway Cancer Alliance
KMCC	Kent & Medway Cancer Collaborative
LSESN	London & South East Sarcoma Network
MFT	Medway Foundation Trust
MTW	Maidstone & Tunbridge Wells NHS Trust
NOG	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)*
PoC	Pathway of Care *(KMCC agreed disease site specific clinical guidelines)*
QEQM	Queen Elizabeth the Queen Mother Hospital, Margate (EKHUFT)
QoL	Quality of life
RMH	Royal Marsden Hospital
RNOH	Royal National Orthopaedic Hospital
QVH	Queen Victoria Foundation Trust Hospital East Grinstead
TSSG	Tumour Site Specific Group
TYA	Teenage & Young Adults
UCLH	University College Hospital London
WHH	William Harvey Hospital, Ashford (EKHUFT)
WK	West Kent

18.0 Document Administration

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Revision History			
Date of revision	New Version Number	Nature of Revision	Confirmation of Accuracy by
Sept 2005	0.1	Initial draft – all sections reviewed & new flow chart	A.Jackson
Sept 2005	0.2	2nd draft – follow up revisions	R.Toye/J.Weeks
Jan 2006	0.3	3rd draft – updated version from collated comments since Dec 2005 DOG	A.Jackson
Feb 2006	0.4	4th draft – revised oncology section and updates from email comments on 3rd draft	C.Harper-Wynne/ A.Jackson/ S.Green
Feb 2006	1.0	Published final (final amendments agreed DOG 6/2/2006)	A.Jackson
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May 2008	1.2	Interim PoC – changes to pages 11 & 12 following email from C.Abson	A.Jackson / C.Abson
May 2009	1.3	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	A.Jackson
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June 2012	3.2	Draft – updated all weblinks inc. imaging, pathology & contacts; general formatting & content checking	C.Tsatsaklas
July 2012	3.3	Draft – deletions from Oncology Provision in line with Breast NOG oncology guidelines	C.Waters/C.Tsatsaklas
July 2012	3.4	Draft – Oncology Provision section updated	C.Waters/C.Tsatsaklas
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January 2013	4.0	Final/Published -agreed revisions from 18/11/2012 Breast DOG included/ratified	Breast DOG/ I.Vousden/C.Tsatsaklas

May 2014	5.0	Final – updates agreed in 29/04/2014 Breast TSSG inc. removal of KMCN, DOG, replace with KMCC, TSSG etc	Breast TSSG/ DHassanally/ CTsatsaklas
May 2015	5.1	DRAFT – wording addition to section 9.3 Axillary Nodes	Breast TSSG/ H.Devalia/ N.Aluwalia
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October 2017	6.2	Updated following TSSG meeting, TSSG ratified. This now needs O&Q ratification prior to publishing	N.Aluwalia
March 2018	7.0	TSSG 20.03.18 agreed Final version	A.Wiltshire
February 2020	7.1	Draft – New chair to review and update	S.Seetharam/A.Wiltshire
March 2021	7.2	Draft – Updated pregnancy section	C. Harper-Wynne
November 2022	7.3	Draft – updated whole document	S. Seetharam
May 2023	8.0	Final – Ratified & agreed by TSSG	S. Seetharam/A. Wiltshire