TIMING OF SURGERY AND CHEMOTHERAPY

C **All treatments for patients with early breast cancer should be started as soon as is practical. Young women with oestrogen receptor negative tumours may benefit particularly from early initiation of chemotherapy following surgery.**

MANAGEMENT OF MENOPAUSAL SYMPTOMS

B **Megestrol acetate or depot intramuscular medroxyprogesterone acetate may be considered to control the severity of hot flushes in women with breast cancer.**

RADIOTHERAPY

ADJUVANT RADIOTHERAPY

A **Radiotherapy should be given following mastectomy or breast conserving surgery to reduce local recurrence where the benefit to the individual is likely to outweigh risks of radiation related morbidity.**

D **The supraclavicular field should be irradiated in all patients with four or more positive axillary modes.**

PSYCHOLOGICAL CARE

THE ROLE OF THE BREAST CARE NURSE

C **All women with a potential or known diagnosis of breast cancer should have access to a breast care nurse specialist for information and support at every stage of diagnosis and treatment.**

☑ Contact details and information about the role of the breast care nurse should be available to the patients, their families and all the members of the multidisciplinary team including the primary care team.

IDENTIFYING DISTRESS

B **The measurement of the presence of psychological symptoms in women with breast cancer should be tailored to the individual circumstances of the patient** *(eg presence of high level of distress or risk factors for problems).*

B **Routinely administered questionnaires are not recommended for the detection of clinically significant psychological symptoms in women with breast cancer who do not have risk factors for severe anxiety or distress.**

☑
- Breast cancer services should routinely screen for the presence of distress and risk factors for very high levels of distress from the point of diagnosis onwards (including during follow up review phases).
- Multidisciplinary teams should have agreed protocols for distress assessment and management. These should include recommendations for referral and care pathways.

PSYCHOLOGICAL SUPPORT FOR WOMEN WITH BREAST CANCER AND THEIR FAMILIES

A **Group psychological interventions should be available to women with breast cancer who feel it would suit their needs. Supportive expressive therapy has been shown to be effective in advanced cancer and cognitive behavioural therapy for localised, locoregional or advanced disease.**

A **Cognitive behavioural therapy** *(in group or individual format according to preference and availability)* **should be offered to selected patients with anxiety and depressive disorders.**

A **Computer and telephone-based interventions should not routinely be offered to patients.**

COMMUNICATION METHODS

A
- **Women with breast cancer should be offered audiotapes or follow up summary letters of important consultations.**
- **Clinical encounters with women with breast cancer should facilitate patient choice about treatment decisions** *(assuming patients wish to participate in the decision making process).*
- **Written agendas, prompt sheets & decisions aids should be used to improve communication with women with breast cancer.**
- **Clinicians should be encouraged to attend validated training in communication skills.**

FOLLOW UP AND PALLIATIVE CARE

C **Mammography should be used to detect recurrence in patients who have undergone previous treatment for breast cancer.**

B **Routine diagnostic tests to screen for distant metastases in asymptomatic women should not be performed.**

B **Patients with breast cancer should have access to input from a specialist palliative care team.**

This Quick Reference Guide provides a summary of the main recommendations in the SIGN guideline on **Management of breast cancer in women.** Recommendations are graded A B C D to indicate the strength of the supporting evidence.

Good practice points ☑ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice. Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: **www.sign.ac.uk**

Information printed in green is extracted verbatim from SIGN 29, the first SIGN guideline on breast cancer published in 1998. This material covers areas that were not updated in the current version of the guideline.

SIGN
Scottish Intercollegiate Guidelines Network

NHS Quality Improvement Scotland

84 Management of breast cancer in women
Quick Reference Guide

December 2005

COPIES OF ALL SIGN GUIDELINES ARE AVAILABLE ONLINE AT WWW.SIGN.AC.UK

DIAGNOSIS AND INVESTIGATION

DIAGNOSIS

C Women should be encouraged to become aware of the feel and shape of their breasts, so that they are familiar with what is normal for them.

C Women should be encouraged to report any change from normal to their general practitioner.

A **Psychological support should be available to women diagnosed with breast cancer at the clinic.**

☑ Referral from primary to specialist care should be made in accordance with the Scottish Cancer Group referral guideline.

INVESTIGATION

B All patients should have a full clinical examination.

B Where a localised abnormality is present, patients should have imaging usually followed by fine needle aspirate cytology or core biopsy.

B A lesion considered malignant following clinical examination, imaging or cytology alone should, where possible, have histopathological confirmation of malignancy before any definitive surgical procedure takes place *(eg mastectomy or axillary clearance).*

D **Patients should be seen at a one-stop, multidisciplinary clinic involving breast clinicians, radiologists and cytology.**

B In patients with symptomatic disease two-view mammography should be performed as part of triple assessment *(clinical assessment, imaging and tissue sampling)* in a designated breast clinic.

B Mammography is not recommended in women under the age of 35 years unless there is a strong suspicion of carcinoma.

C **Magnetic resonance imaging should be considered in specific clinical situations where other imaging modalities are not reliable, or have been inconclusive, and where there are indications that MRI is useful.**

SYSTEMIC THERAPY

ADJUVANT CHEMOTHERAPY

A **All women under the age of 70 years, with early breast cancer should be considered for adjuvant chemotherapy.**

C **Women with ER-positive tumours who receive chemotherapy should be considered for additional endocrine therapy, especially if they are under 35 years.**

SYSTEMIC THERAPY (CONTD.)

ANTHRACYCLINE AND TAXANE THERAPY

Taxanes are active in the adjuvant setting, but although they have been shown to improve upon some adriamycin-based regimens, there are not yet any published data that they offer additional survival benefits over optimal anthracyclines regimens.

A **Anthracyclines should be prescribed in preference to non-anthracycline regimens in the adjuvant setting, as they offer additional benefits. Epirubicin may be preferred as it causes less cardiac adverse effects.**

A **Taxanes should be considered in patients with advanced disease.**

BIOLOGICAL THERAPIES

C **Trastuzumab should be reserved for those patients whose tumours have HER2 over-expression.**

A **Combination therapy of trastuzumab with a taxane is recommended in women with metastatic breast cancer as it is associated with a survival advantage compared to taxane therapy alone.**

BISPHOSPHONATES

A **Bisphosphonates should be routinely used in combination with other systemic therapy in patients with metastatic breast cancer with bone metastases. The choice of agent for an individual patient depends on individual circumstances.**

ENDOCRINE THERAPY

A **Premenopausal women whose tumours are not shown to have absent oestrogen or progesterone receptors should be considered for adjuvant endocrine therapy.**

A
- **In postmenopausal women with breast cancer tamoxifen remains the treatment of choice as initial therapy in the adjuvant setting. If there are relative contraindications to its use** *(high risk of thromboembolism or endometrial abnormalities)* **or intolerance, an aromatase inhibitor can be used in its place.**
- **Postmenopausal patients should be considered for a switch to an aromatase inhibitor after either two to three years or after five years of tamoxifen therapy.**
- **In postmenopausal women with advanced disease, third generation aromatase inhibitors should be considered before either tamoxifen or megestrol acetate.**

A **In advanced disease, the combination of tamoxifen plus ovarian ablation should be offered ahead of tamoxifen therapy alone.**

SURGERY

CONSERVATION SURGERY VERSUS MASTECTOMY

A
- **All women with early stage invasive breast cancer who are candidates for breast conserving surgery should be offered the choice of breast conserving surgery** *(excision of tumour with clear margins)* **or modified radical mastectomy.**
- **The choice of surgery must be tailored to the individual patient, who should be fully informed of the options and who should be aware that breast irradiation is required following conservation and that further surgery may be required if the margins are positive.**

C **Breast conserving surgery is contraindicated if:**
- **the ratio of the size of the tumour to the size of the breast would not result in acceptable cosmesis**
- **there is multifocal disease or extensive malignant microcalcification on mammogram**
- **there is a contraindication to local radiotherapy** *(eg previous radiotherapy at this site, connective tissue disease, severe heart and lung disease, pregnancy).*

C The possibility of breast reconstruction should be discussed with all patients prior to mastectomy.

SURGICAL MANAGEMENT OF THE AXILLA

A **Axillary surgery should be performed in all patients with invasive breast cancer.**

MANAGEMENT OF DUCTAL CARCINOMA IN SITU

B **Women with ductal carcinoma in situ who are candidates for breast surgery should be offered the choice of lumpectomy or mastectomy.**

A **Women who have undergone breast conserving surgery should be offered postoperative breast irradiation.**

☑ The benefits and harms of hormonal therapy should be discussed with women with ductal carcinoma in situ and treatment decisions made based on individual circumstances.