Breast Cancer – Established

Disclaimer

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The purpose of this pathway is to give an overview of the specialist management of breast cancer. The predominant role of the general practitioner during active treatment is to:

- provide psychosocial support and lifestyle advice.
- monitor medication compliance and side-effects.
- identify complications of treatment e.g., infection associated with neutropenia.
- avoid or defer minor procedures e.g., routine cervical screening during chemotherapy treatment.

See also the Chemotherapy and Infection information.

**Red flags**

- Tamoxifen and concomitant CYP2D6 inhibitors
- Symptoms or signs suggestive of metastatic disease (e.g. constitutional symptoms, CNS symptoms or signs)
- Vaginal bleeding in patients taking hormone therapy

**Assessment**

**Aboriginal and Torres Strait Islander care.**

1. **Ask** and record if the patient identifies as being of Aboriginal or Torres Strait Islander origin. Consider the specific cultural and spiritual needs of each patient.

   ➢ **Advice for communicating with Aboriginal and Torres Strait Islander people**
      - Encourage patients to book a longer consultation, to allow sufficient time for discussion and building trust.
      - Only use traditional terminology such as "Aunty" and "Uncle" if invited to do so.
      - Consider the role of factors such as gender, kinship, family ties, language barriers and socioeconomic issues.
      - Offer the patient:
        - the option of seeing a health professional of the same gender or if this is not possible, referral to another service.
        - the option to have support person present, such as a family member, a community member, or an Elder.
        - access to funding assistance to overcome any identified or potential financial barriers e.g., ITC Funding. See SEMPHN Aboriginal and Torres Strait Islander health

   ➢ Acknowledge and respect how cultural, spiritual and historical beliefs and experiences impact on decision-making.

   **Respecting Aboriginal and Torres Strait Islander people’s decision-making processes**
   - Aboriginal and Torres Strait Islander knowledge, values, beliefs, cultural needs, and health history may strongly inform decision-making processes about treatment and ongoing care.
   - If possible and if requested by the patient, support the inclusion of cultural practices e.g., involvement of a traditional healer, or performing ceremonies.

   ➢ Be aware the term “survivor” may have negative connotations for historical reasons.

   ➢ Proactively explore and monitor symptoms of pain.

   **Considerations for assessing and managing pain in Aboriginal and Torres Strait Islander people**
   - Aboriginal and Torres Strait Islander patients may not actively report pain or other needs.
   - Offer patients the option to discuss their needs with a health professional of the same gender.
   - If available, use a pain tool that is culturally appropriate for the local community.
• Allow sufficient time to discuss and explain the options, usage, and side-effects of pain relief in full.
• Be aware of:
  o significant cultural practices regarding which family members can assist with providing pain relief, and how pain medication is administered.
  o fears that pain relief medicines may accelerate the passing of the patient.

➢ Understand how the concept of **family** is different for Aboriginal and Torres Strait Islander people.

**Considerations when discussing family with Aboriginal and Torres Strait Islander people**

For Aboriginal and Torres Strait Islander people:
• the concept of family is broader than being genetically related.
• be sensitive when taking a family history, as discussing members of the stolen generation may be distressing
• Be sensitive when referring to people who have died – check and ask permission. There may be cultural taboos in discussing Sorry Business (referring to people who have died).

➢ Be supportive and understanding if **appointments** are missed, and facilitate follow-up or rebooking.

**Appointments for Aboriginal and Torres Strait Islander people**
• Patients who identify as Aboriginal and Torres Strait Islander people may have complex factors e.g., family and community responsibilities, or previous experiences with mainstream medical services, that make it difficult for them to attend appointments.
• The following supports may facilitate this process:
  o Recall and reminders
  o ITC funding
  o Referral to an Aboriginal Liaison officer, support, or health worker.

➢ Aboriginal and Torres Strait Islander people are more likely to have multiple co-morbidities that can impact treatment outcomes.

➢ Ensure contact details are up to date.

➢ If available, use **assessment tools and resources** designed specifically for Aboriginal and Torres Strait islander people.

**Aboriginal and Torres Strait Islander assessment tools and resources**
➢ See **SCNAT-IP** – online tool that assesses the supportive care needs of Aboriginal and Torres Strait Islander cancer patients and their families.

➢ **Ask if the patient identifies as being of Aboriginal or Torres Strait Islander origin**
If a patient or their family want to know why you are asking this question, you may reply with:
• We ask this question of everyone.
• It enables us to help you access extra services that are funded for Aboriginal and Torres Strait Islander peoples, such as support to buy medications and extra funded visits with some health care providers.
• This information helps our practice and the health care providers we refer you to, to provide culturally safe care.

For more information, see the RACGP’s **Five steps towards excellent Aboriginal and Torres Strait Islander healthcare**.
Breast cancer is the most commonly diagnosed cancer in Aboriginal and Torres Strait Islander women.

Five-year breast cancer survival rates for this group are lower compared with non-Aboriginal women.

2. Take a **history** and screen for **physical issues**.

   - **Physical issues**
     - Fatigue and decline in general health
     - Loss of appetite and nutritional deficiencies
     - Pain
     - Lymphoedema
     - Disfigurement or wound odour
     - Cognitive problems and difficulties in communication
     - Need for contraception post-treatment
     - Vaginal dryness or bleeding

   - **Take a history**
     - Ask about breast and axillary symptoms, and signs and side-effects of therapy.
     - Enquire about the impact of the diagnosis and treatment (including the impact on fertility).
     - Ensure the patient understands their staging and prognosis.

3. Review patient's proposed shared-care follow up plan which will be outlined in the patient's **multidisciplinary discharge summary** from oncology services.

   - **Multidisciplinary discharge summary**
     - Most importantly should include what the patient has been told. This may include:
       - intentions.
       - goals and quantitative benefit of proposed treatment.
       - recurrence risk if known.

     - Usually includes:
       - diagnostic tests performed and results.
       - tumour characteristics and other factors determining prognosis.
       - type and date of treatments and a treatment summary.
       - expectations of disease course, including expected discharge from oncology services.
       - interventions and treatment plans from other health professionals.
       - a process for rapid re-entry to specialist medical services for suspected recurrence.
       - a list of symptoms that might need prompt investigation.
       - a list of supportive care services provided and a plan for community care services, including what each service is to provide.
       - contact information for key care providers.

4. Only examine the patient's breasts, wounds, and axillae if intercurrent issues arise or if the patient has concerns.
1. Discuss the **intention of treatment** and risk of **metastasis or recurrence** with the patient, and determine their understanding of it.

   - **The intention of treatment**
     - Curative
     - Improved longevity or quality of life
     - Palliative

   ➢ **Factors influencing risk of recurrence**
     - Factors to consider:
       - Patient’s age
       - Size and grade of primary tumour
       - Lymphovascular invasion and a higher number of lymph nodes (LNs) involved
       - Hormone receptor (HR) status – oestrogen (ER) and progesterone (PR) and HER2 status.
     - Low risk patients:
       - Small, hormone driven, node negative tumours
       - Oncologist involvement usually lasts 5 years
     - Intermediate risk patients:
       - HR positive tumours with low (1 to 3) number of lymph nodes
       - Triple negative (oestrogen, progesterone, and HER2 negative) tumours with non-extensive nodal involvement of < 10 mm diameter
       - HER 2 positive tumours with no nodes involved
     - High risk patients:
       - Triple negative, node positive disease
       - Nodes positive and HR positive, with or without HER2 positive
       - Extensive nodal involvement
       - Aged < 35 years

   ➢ See Clinical Medicine and Research – Overall (A) and Disease-Free (B) Survival by Tumor Subtype for information about survival rates based on hormone receptor and HER2 status.

   ➢ See also LifeMath – Breast Cancer Conditional Outcome Calculator.

2. Explore the patient’s understanding of treatment options, including:

   - **surgery** with or without **adjuvant treatments** for early breast cancer.

   ➢ **Surgery**
     
     Surgery for early breast cancer involves either breast conserving surgery or mastectomy, with or without breast reconstruction or breast prostheses. Mastectomy is indicated for extensive in situ or invasive cancer. Discuss with patients their expectations or concerns about expected post-surgical appearance.

   - **Breast conserving therapy (BCT)**
     - BCT (lumpectomy) is followed by radiotherapy in early or locally advanced breast cancer.
     - Be aware that women aged < 45 years may be offered a mastectomy due to latest survival study results.

   - **Unilateral mastectomy**
     - Unilateral mastectomy is likely to be considered for:
       - relatively large in situ cancers.
       - multifocal or inflammatory tumours.

   - **Axillary lymph node dissection**
Axillary lymph node dissection is performed in women who have breast cancer with pathologically confirmed lymph nodes involvements.

Sentinel lymph node biopsy results in fewer arm complications compared with axillary lymph node dissection.
- Sentinel node biopsy is performed at initial breast surgery if status of the regional nodes is unknown.
- Sentinel node involvement may indicate the need for axillary dissection.
- Consider referral for lymphoedema prevention.

**Prophylactic double mastectomy**
- Prophylactic double mastectomy is increasingly used if there is breast cancer (BRCA) mutation.
- There is no data to show that a bilateral mastectomy improves outcome or survival for women without this mutation.

**Bilateral mastectomy**
- Bilateral mastectomy is usually performed as prophylaxis, and is not associated with lower mortality than breast-conserving surgery, plus radiation.

**Breast reconstructive surgery**
- Breast reconstructive surgery can be costly, and there may be limited availability in the public system.
- If breast reconstructive surgery is indicated:
  - plan as appropriate for immediate or delayed surgery.
  - refer to a plastic surgeon for surgical assessment – discuss early with the breast surgeon as patient may need to be referred out of area.
- Some reconstructive procedures are performed by oncoplastic breast surgeons.
  - **Oncoplastic breast surgeons**
    
    This is a relatively new subspecialty of breast surgery requiring registration and training. See Breast Surgeons of Australia and New Zealand – Oncoplastic Breast Surgery.
- See also External Breast Prostheses Reimbursement Program

**Adjuvant treatments**
Adjuvant treatments for early breast cancer are routinely used and include:

**Radiation therapy**
- If early breast cancer, radiation therapy is given after:
  - breast-conserving surgery.
  - mastectomy, for selected women.
- Usually 5 to 7 weeks, 5 days per week.
- Consider effect on reconstruction or further surgery, which will have been discussed by the treating surgeon.

Advantage over surgery:
- Axillary radiotherapy has advantages over surgical axillary clearance, with arguably lower rates of lymphoedema.
- Consider referral for lymphoedema prevention.

**Adjuvant systemic therapy**
- Chemotherapy, hormonal therapy or biologics may be used as neoadjuvant or adjuvant treatment. Indications include:
  - positive nodes
  - large tumour
  - aggressive cell type
  - menopausal status
o conducive hormonal status
o genetic or protein status of the tumour.

- Chemotherapy
  o Treatment is parenteral, requires admission, even if it is day-stay, and requires vigilance for complications such as neutropaenia.
  o Taxanes – commonly used, often cause neurological toxicity.
  o Anthracyclines – used for many years. Concerns about cardiotoxicity and late leukaemia.

See also information on Chemotherapy and Infection.

- Hormonal therapy
  o Has a very low risk of neutropaenia, and hospital supervision is not required.
  o Tamoxifen – used in oestrogen receptor positive breast cancer, inhibiting growth of dormant cells or micrometastases.
  o Aromatase inhibitors – prevent steroid hormones conversion to oestrogen.
  o Tamoxifen and aromatase inhibitors cause significant vaginal dryness, soreness, and even bleeding. Prevent or treat as appropriate.

  ▪ Treatment of vaginal dryness in oestrogen-sensitive cancers
    - Non-hormonal treatments are first-line in oestrogen-sensitive cancers of the breast, ovaries, and endometrium.
    - Evidence does not support an increased risk of cancer recurrence in women using vaginal oestrogen while undergoing treatment for (or with a personal history of) breast cancer.
    - Consider lubricant with intercourse, and Replens as first-line moisturiser.
    - Discuss with treating specialist before commencement of vaginal oestrogen.

- Biologics
  o Trastuzumab is given by parental infusion every 3 weeks. It may sometimes be used with chemotherapy agents or with radiotherapy.
  o Other targeted chemotherapy agents are used increasingly in research.

  For more information see:

  o American Cancer Society – What’s New in Breast Cancer Research
  o Australian Government Cancer Australia:
    ▪ Clinical Practice Guidelines for the Management of Early Breast Cancer (2nd ed)
    ▪ Recommendations for the Management of Early Breast Cancer in Women with an Identified BRCA1 or BRCA2 Gene Mutation or at High Risk of a Gene Mutation.

- Treatment of metastatic disease and palliative care.
  - Metastatic disease and palliative care
    o May be controlled by medications and surgery for many years.
    o Palliative radiation treatment is often useful for bone metastases.
    o Early involvement of palliative care team is optimal for metastatic cancer. See:
      o Palliative Care.
3. **Manage any physical issues** or intercurrent health problems detected.

**Manage any physical issues**
- Fatigue and decline in general health
- Loss of appetite and nutritional deficiencies
- Pain
- Lymphoedema
- Disfigurement or wound odour
- Cognitive problems and difficulties in communication
- Fertility:
  - Options for preservation of fertility prior to treatment
  - Issues with fertility after treatment including the need for contraception

- **Vaginal dryness or bleeding**
  - Non-hormonal treatments are first-line in oestrogen-sensitive cancers of the breast, ovaries, and endometrium.
  - Evidence does not support an increased risk of cancer recurrence in women using vaginal oestrogen while undergoing treatment for (or with a personal history of) breast cancer.
  - Consider lubricant with intercourse, and Replens as first-line moisturiser.
  - Discuss with treating specialist before commencement of vaginal oestrogen.

  - Contact the treating specialist if there have been any significant intercurrent health events or co-morbidity changes. This can alter treatment and prevent futile interventions.

4. Review medications. Check for **CYP2D6 inhibitors** e.g., selective serotonin reuptake inhibitors (SSRIs) or cimetidine, which can interfere with the efficacy of tamoxifen.

  - **CYP2D6 inhibitors**
    - Bupropion (strong)
    - Celecoxib, cimetidine, cinacalcet (moderate), cobicistat
    - Duloxetine (moderate)
    - Fluoxetine (strong)
    - Methadone, mirabegron
    - Paroxetine (strong)
    - Terbinafine (moderate)
    - See also Mayo Clinic – [Cytochrome P450 2D6 Known Drug Interaction Chart](#).
    - If in doubt about other CYP2D6 inhibitors, seek pharmacy advice or consult with the treating oncologist.

5. If patient identifies as Aboriginal or Torres Strait Islander, understand their specific cultural and spiritual needs when discussing and delivering treatment options, including eligibility for [Care Coordination and Supplementary Services (CCSS)](#).

- **Cultural and spiritual considerations for Aboriginal and Torres Strait Islander People**
  - Offer referral to culturally appropriate social and emotional [wellbeing services](#).
  - Consider including an expert in the multidisciplinary team (such as a Aboriginal Liaison Officer), to provide culturally appropriate care to Aboriginal and Torres Strait Islander people.
  - Provide culturally appropriate information or resources about the signs and symptoms of recurrent disease, secondary prevention, and healthy living.
Ongoing care and support

1. Provide the patient with the Cancer Council Australia What to Expect: Breast Cancer document.
2. See Cancer Supportive Care for general advice on:
   - lifestyle changes.
   - psychological needs.
   - financial, legal, and practical needs.
   - managing physical sequela.
   - support groups and referral services.
3. Consider early referral to palliative care where appropriate.
4. Provide ongoing support of patient and family throughout the course of cancer treatment and survivorship.
   - Consider advance care planning.
   - Arrange counselling support.
   - Consider GP management plan and team care arrangement.

Referral

➢ Refer to a breast surgeon or for oncology assessment if:
   - any complications resulting from the above procedures or treatments.
   - symptoms of progressive breast cancer e.g., localised skin, breast or nipple changes, or axillary lumps.
   - symptoms or signs suggestive of metastatic disease (e.g. constitutional symptoms, CNS symptoms or signs).
   - on tamoxifen, and if you consider the patient needs CYP2D6 inhibitors for co-morbidities, as hormonal therapy alternatives may be possible.

➢ If the patient is on tamoxifen and needs CYP2D6 inhibitors e.g., selective serotonin reuptake inhibitors (SSRIs) or cimetidine, seek pharmacy advice or discuss with treating oncologist as significant interference with tamoxifen efficacy may occur.

   • CYP2D6 inhibitors
     - Bupropion (strong)
     - Celecoxib, cimetidine, cinacalcet (moderate), cobicistat
     - Duloxetine (moderate)
     - Fluoxetine (strong)
     - Methadone, mirabegron
     - Paroxetine (strong)
     - Terbinafine (moderate)

   See also Mayo Clinic – Cytochrome P450 2D6 Known Drug Interaction Chart.

➢ If breast reconstruction is considered:
   - discuss options with the patient’s breast surgeon or plastic surgeon.
   - see External Breast Prostheses Reimbursement Program.

➢ Refer to a lymphoedema practitioner for assessment and management of lymphoedema.

➢ Consider involving palliative care services if metastatic disease.

➢ Discuss with breast surgeon and oncologist appropriate fertility assessment and referral for women seeking advice about preservation of fertility prior to treatment.

➢ Refer for psychological assessment and treatment if indicated.
If Aboriginal or Torres Strait Islander patient, offer referral to specific Indigenous services. For all referrals, to both mainstream and Indigenous services, ensure Indigenous status is clearly marked on the referral.

- **Referral Options for Aboriginal and Torres Strait Islander people**
  - For hospital referrals, consider engaging support from the Aboriginal Hospital Liaison Officers.
  - For community referrals, consider referral to an Aboriginal Community Controlled Health service.
  - For care coordination, support and advocacy throughout treatment, consider referral to Care Coordination and Supplementary Services (CCSS).

**Information**

**For health professionals**

Further information

- American Cancer Society – Breast Cancer Stages
- Australian Government Cancer Australia: Clinical Practice Guidelines for the Management of Early Breast Cancer (2nd ed) Psychosocial Guidelines
- NSW Government eviQ: Medical Oncology: Breast Radiation Oncology: Breast

For patients

- Cancer Council: Breast Cancer
- Breast Cancer: What to Expect
- Cancer: What to expect
- National Indigenous Cancer Network – About Cancer
- NSW eviQ – Patients and Carers

**References**

**References**


**Select bibliography**
