

Optimal care pathway for women with breast cancer

Quick reference guide



Please note that not all women will follow every step of this pathway:

Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

Step 1

Prevention and early detection

Risk factors: Age, sex, family history, obesity and moderate/heavy alcohol intake are important risk factors. All women should have their individual breast cancer risk assessed.

Women at moderate or high risk should be referred to a family cancer clinic to have their risk further clarified and for possible genetic testing.

Risk reduction: For women at moderate or high risk of breast cancer, anti-hormonal risk-reducing

medication should be considered. Women at very high risk should consider risk-reducing surgery. The surgeon should provide clear information about the objective of the procedure.

Screening: Federally funded mammographic screening is available to asymptomatic women from the age of 40

through the BreastScreen Australia Program. Women aged 50-74 years should consider undergoing a two - yearly screening mammogram. Over-diagnosis needs to be considered, and women invited to screening must be informed of the potential disadvantages as well as the benefits of mammographic screening.

Increased or high risk - refer to the breast optimal care pathway for screening recommendations.

Step 2

Presentation, initial investigations and referral

Signs and symptoms:

The following should be investigated:

- a new lump or lumpiness
- a change in the size or shape of a breast
- a change to a nipple
- nipple discharge that occurs without squeezing
- a change in the skin of a breast
- axillary masses
- an unusual breast pain that does not go away.

Assessments by a general practitioner (GP)

GP should refer all women with a suspicious lesion to a breast assessment clinic.

Examinations/investigations should include a triple test of three diagnostic components:

- medical history and clinical breast examination

- imaging – mammography and/or ultrasound
- non-excision biopsy – fine needle aspiration (FNA) cytology and/or a core biopsy.

These tests should be done within two weeks.

Referral: A positive result on any component of the triple test warrants referral for specialist surgical assessment and/or further investigation. Optimally, the specialist appointment should be within two weeks of a suspected diagnosis.

Communication – lead clinician to:

- provide the woman with information that clearly describes who they are being referred to, the reason for referral and the expected timeframe for an appointment
- support the woman while waiting for the specialist appointment.

Step 3

Diagnosis, staging and treatment planning

Diagnostic work-up for women with breast cancer:

Family history and a medical examination, then consider following sequence of investigations:

- breast imaging tests
- ultrasound of the axilla +/- FNA nodes
- breast core biopsy if not already undertaken
- establishment of breast cancer receptor profile
- assessment for a breast cancer predisposition gene and considered for genetic counselling.

Staging: Appropriate for locally advanced or confirmed nodal disease and for any women with clinical symptoms or clinical suspicion of metastatic disease.

Treatment planning: All newly diagnosed women should be discussed by a multidisciplinary team so

that a treatment plan can be recommended.

Special considerations that need to be addressed at this stage include pregnancy, fertility and prevention of chemotherapy-induced menopause.

Research and clinical trials: Consider enrolment where available and appropriate.

Communication – lead clinician to:

- discuss a timeframe for diagnosis and treatment with the woman/carer
- explain the role of the multidisciplinary team in treatment planning and ongoing care
- provide appropriate information or refer to support services as required.

¹ Lead clinician – the clinician who is responsible for managing patient care.

The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

Step 4

Treatment:

Establish intent of treatment:

- curative
- anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- symptom palliation.

Treatment options:

Surgery: Surgery for early breast cancer involves either breast-conserving surgery or mastectomy performed with or without immediate breast reconstruction surgery. Women should be fully informed of their options and offered the option of immediate or delayed reconstructive surgery if appropriate.

Chemotherapy and other systemic therapy:

Chemotherapy or drug therapy may be appropriate as neoadjuvant or adjuvant treatment.

Radiation therapy: In most cases, radiation therapy is recommended for women with early breast cancer after breast-conserving surgery and in selected women after mastectomy.

For detailed information see <<http://canceraustralia.gov.au/publications-and-resources/cancer-australia-publications/clinical-practice-guidelines-management-early-breast-cancer-2nd-ed>>.

Communication – lead clinician to:

- discuss treatment options with the woman/carer including the intent of treatment and expected outcomes
- discuss the treatment plan with the woman's GP.

Step 5

Care after initial treatment and recovery

Cancer survivors should be provided with the following to guide care after initial treatment.

Treatment summary (provide a copy to the woman/carer and her GP) outlining:

- diagnostic tests performed and results
- tumour characteristics
- type and date of treatment(s)
- interventions and treatment plans from other health professionals
- supportive care services provided
- contact information for key care providers.

Follow-up care plan (provide a copy to the woman/carer and her GP) outlining:

- medical follow-up required (tests, ongoing surveillance)
- care plans for managing the late effects of treatment
- a process for rapid re-entry to medical services for suspected recurrence.

Communication – lead clinician to:

- explain the treatment summary and follow-up care plan to the woman/carer
- inform the woman/carer about secondary prevention and healthy living
- discuss the follow-up care plan with the woman's GP.

Step 6

Managing recurrent, residual and metastatic disease

Detection: Some cases of recurrent disease will be detected by routine follow-up in a woman who is asymptomatic. Some cases of metastatic disease will be detected at the same time as presentation with the initial primary breast cancer ('de novo metastatic disease').

Treatment: Where possible, refer the woman to the original multidisciplinary team. Treatment will depend on the location, the extent of recurrence, previous management and the woman's preferences.

Palliative care: Early referral can improve quality

of life and in some cases survival. Referral should be based on need, not prognosis.

For detailed information see <<http://annonc.oxfordjournals.org/content/early/2014/09/17/annonc.mdu385.full.pdf+html>>.

Communication – lead clinician to:

- explain the treatment intent, likely outcomes and side effects to the woman/carer
- initiate a discussion regarding advance care planning if appropriate.

Step 7

End-of-life care

Palliative care: Consider referral to palliative care if not already involved. Ensure that an advance care plan is in place.

Communication – lead clinician to:

- be open about the prognosis and discuss palliative care options with the woman/carer
- establish transition plans to ensure the woman's needs and goals are addressed in the appropriate environment.

Visit www.cancerpathways.org.au for consumer friendly guides. Visit www.cancer.org.au/OCP for the full clinical version and instructions on how to import these guides into your GP software.