

## Guideline for the Follow Up of Patients Following Treatment for Breast Cancer

<b>Date Approved by Network Governance</b>	July 2012
<b>Date for Review</b>	July 2015

## **1 Scope of the Guideline**

This guideline has been produced to support the routine follow up of patients after treatment for breast cancer.

## **2 Guideline Background**

The NICE Clinical Guideline GC80 for early and locally advanced breast cancer recommends limited (up to three years) clinical follow up after treatment for early stage breast cancer, and that patients' are then discharged back to primary care. It states that the aims of follow up are to detect and treat local recurrence and adverse effects of therapy. It recommends continuing access for an indefinite period to a breast care nurse for telephone advice and who can arrange immediate breast clinic appointments if indicated.

## **Guideline Statements**

### **3 Clinical Follow-up**

- 3.1 Clinical follow-up of patients undergoing primary endocrine therapy should be offered for a minimum of 12 months after initiation of treatment, to ensure a response. Further follow-up will depend on clinical fitness and patient situation.
- 3.2 Clinical follow-up after treatment for DCIS and early breast cancer (NPI of < 4.3) should be annual review for up to three years following the completion of definitive surgical treatment.
- 3.3 Patients with breast cancer (NPI  $\geq 4.3$ ) **can** be offered annual review for 5 years after completion of surgical treatment but should usually be discharged from routine clinical follow up after 3 years.
- 3.4 After discharge from hospital follow-up, the primary care is expected to manage patients' hormonal therapy, including changes in switch programmes. Pathways of care should be agreed to ensure patients having problems with hormonal therapy can be easily reviewed by the specialist team.
- 3.5 Hospital follow-up of patients with metastatic disease is individualised according to their clinical need.
- 3.6 Patients within a clinical trial should be followed up as per trial protocol, with longer term outpatient clinical follow-up only done when mandated as part of that trial.
- 3.7 Hospital follow-up should be carried out by someone who is a core member of the MDT suitably trained and supported.

- 3.8 At each follow-up visit the following information should be re-iterated with the patient:
- a. How to access the breast care team between visits and after discharge.
  - b. Signs and symptoms that should be reported to the breast care team (between visits and after discharge) for further investigation.
- 3.9 Patients should be discharged to primary care, with detailed information (to the primary care team) regarding the patient's:
- a. disease,
  - b. treatment,
  - c. understanding of their disease and treatment to date
  - d. expectation of any ongoing treatments
  - e. required investigations (see below)
  - f. treatment plan regarding ongoing endocrine treatment
- 3.10 The primary care team should, unless requested not to by the patient, ensure that the patient is referred back to the MDT who treated the patient's cancer originally. The primary care team should be informed how to re-refer to the treating team directly including arrangements for patient initiated direct access to the breast team as appropriate.
- 3.11 Self referral back to the breast MDT: Patients discharged from clinical follow-up should have open access back to the treatment team (bypassing choose and book) and they should have written information as to how to achieve this – without the need to visit their GP.

#### **4 Radiological Follow-up**

- 4.1 Patients over the age of 45 with no known active disease should be offered annual mammography for five years after diagnosis, and then be discharged to the NHS national breast cancer screening programme (NHSBSP). Once they reach 70 years they should be advised that they can continue to opt into the NHS national breast cancer screening programme (NHSBSP).
- 4.2 Patients who are aged between 35 and 45 at diagnosis should be offered annual mammography until the age of 50 and then be discharged to the national screening programme (NHSBSP).
- 4.3 Patients under the age of 35 at diagnosis should be discussed by the MDT in order to agree an individualised imaging follow up plan.
- 4.4 Mechanisms should be in place within the Trust for imaging follow-up and review of the results to be organised by the breast cancer team.
- 4.5 Patients should be informed of the result of their follow up imaging within 3 weeks of the investigation being performed.
- 4.6 Patients who are over the age of 70 on completion of mandated follow up should be made aware of the availability of 3 yearly mammography through the NHSBSP and how they can access it.

- 4.7 Patients on aromatase inhibitors should have a baseline bone density scan as defined in the non surgical treatment for breast cancer guideline – point 7.6.2 <http://www.birminghamcancer.nhs.uk/staff/clinical-guidelines/breast-cancer>

## 5 Patient Education

- 5.1 Patient education is the single most effective way of ensuring early detection of metastatic disease or local recurrence. MDT's should ensure that there are local programmes and written information in place to deliver this. This should include the opportunity for patients to attend a group or a one to one session and all patients should be given written information pertinent to their diagnosis, treatment and ongoing management.

### 5.2 Bony Metastases

5.2.1 All patients diagnosed with a metastasis to **any bone**, or who have **myeloma**, should receive information about the possibility of developing metastasis to the spine. This is essential to enable patients to report signs of spinal metastases early, thereby offering treatment options that may prevent damage to the spinal cord and unnecessary disability.

5.2.2 This information should be offered by a senior cancer clinician (for example a CNS or consultant). The patients should be advised about what to look for and what to do in the event that they have symptoms and/or signs of spinal metastases.

5.2.3 Patients should be provided with information about the symptoms and/or signs of spinal cord compression and what to do if they develop them. This discussion should be supported by written information in the form of the PBCN Patient Information on Cancer that has Spread to the Bone (Bone Metastases) and the Patient Alert Cards.

## 6 Patient information and counselling

6.1 All patients, and with their consent, their partners should be given access to appropriate written information during their disease and treatment, and will be given the opportunity to discuss their follow-up and endocrine treatment (where applicable) at any time with a clinical nurse specialist who is a member of the breast multidisciplinary team. The patient should have clear advice on how to get rapid and direct access to the breast team if they or their GP are concerned about the possibility of a recurrence.

6.2 Access to psychological support for those diagnosed with breast cancer should be available if required. All patients should undergo a full Holistic Needs Assessment at discharge and at other times as required.

## Monitoring of the guideline

Adherence to the Network guidelines may from time to time be formally monitored.

## References

1. National Institute for Clinical Excellence 2009, Guidelines for Early and Locally Advanced Breast Cancer (diagnosis and treatment).
2. The clinical effectiveness and cost effectiveness of different surveillance mammography regimes after the treatment for primary breast cancer: systematic reviews registry database analyses and economic evaluation. Health Technology assessment 2011; 15 (34): 1-322
3. Breast Cancer (Early and Locally Advanced) NICE Guidance - CG80  
<http://guidance.nice.org.uk/CG80/Guidance/pdf/English>

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