Pan Birmingham NHS
Cancer Network

Guideline for the Surgical Management of Breast Cancer

Version History

Version	Date	Summary of Change/Process
3.0	04.09.08	Endorsed by the Governance Committee
3.1	26.07.11	Reviewed and updated by Lara Barnish before circulation to Breast Network Site Specific Group
3.2	19.08.11	Reviewed and updated by Martin Sintler and circulated to Breast Network Site Specific Group for reviewing
3.3	26.08.11	Reviewed and updated by Martin Sintler following comments received. Circulated to Breast Network Site Specific Group for final review
3.4	20.09.11	Reviewed and approved by Breast Network Site Specific Group
3.5	20.10.11	With comments from Lara Barnish
3.6	25.10.11	Minor amendments by Martin Sintler received and incorporated
4.0	02.11.11	Reviewed and endorsed by Guidelines Sub Group

Date Approved by Network Governance	**November 2011**

Date for Review	**November 2014**

Changes made during the review process in 2011

Changes have been made to comply with recommendations from NICE (2009) and Association of Breast Surgeons (ABS) at BASO (British Association of Surgical Oncologists) (2009). Sentinel node biopsy has now become standard practice for management of the axilla in clinically and radiologically node negative patients.

1. Scope of the Guideline

This guideline has been produced to describe and support the following:

- principles to follow when deciding on the type of breast surgery
- the management of the axilla including sentinel node biopsy
- breast reconstruction
- surgical management of recurrent breast disease

2. Guideline Background

2.1 The management of breast cancer has moved forward with the general introduction of sentinel lymph node biopsy. National guidelines have been updated (NICE[1] and ABS at BASO[3]). This document updates the Pan Birmingham Cancer Network guidelines in line with national guidelines.

Guideline Statements

3. Breast Surgery

3.1 Breast surgery should be carried out by a designated breast surgeon, who operates as part of a breast MDT[1], or by a trainee under the supervision of a designated breast surgeon.

3.2 Only surgeons with an interest in the management of breast disease should treat patients with breast cancer[3]. Those consultant surgeons should have a minimum caseload of 30 new breast cancer patients per year[*].

3.3 Breast surgeons should treat at least 10 NHS Breast Screening Program cancers per year.

3.4 Specialist breast surgeons should spend at least 50% of their direct clinical care on patients with breast cancer[4].

3.5 Breast conserving surgery should always be considered and discussed with the patient as appropriate. Patients should be given an informed choice.

3.6 Preoperative sizing of the tumour should be undertaken. Where there is discordance between clinical and radiological sizing, MRI should be considered.

[*] This refers to caseload, not surgical procedures, and includes both NHS and private practice. Assessment of caseload should be averages over 3 years and take into account length of time in post and other similar factors.

3.7 All patients presenting with lobular breast cancer being considered for breast conserving surgery (BCS) should have the tumour size and focality checked with an MRI scan.

3.8 All patients having a mastectomy should have the merits of reconstruction discussed.

3.9 Patients undergoing surgery for radiologically localised lesions should have the specimen assessed radiologically intra operatively and within 20 minutes of it being requested?

3.10 Each breast unit should have a policy for breast specimen orientation and pathological handling.

3.11 Local protocols should be developed by MDTs to describe the marking required of the surgical cavity for the purpose of targeted postoperative radiotherapy. Margins should be marked by the insertion of cavity clips at the time of surgery. This is especially important when oncoplastic techniques have been used.

3.12 Surgical margins should be pathologically clear. A minimum radial margin of 2mm is recommended. Breast units should develop their own protocols based around this. Close anterior and posterior margins may be considered less important depending on the type of surgery.

3.13 If the surgical margins are <2mm, an appropriate cavity shave should be performed to obtain good pathological clearance. The risks and benefits should be discussed with the patient.

3.14 Oncoplastic breast conserving operations should satisfy the same local protocol for margins as wide local excisions and the local protocols for margins.

3.15 Patients being treated for ductal carcinoma in situ (DCIS) should be entered into the Sloane project (UK DCIS audit[5])

3.16 Patients being treated for symptomatic breast cancers will be entered into the Breast Cancer Clinical Outcome Measures (BCCOM) project, West Midlands Cancer Intelligence Unit (WMCIU)

3.17 Breast units should audit their local recurrence rates.

3.18 All patients should have access to a specialist breast care nurse to support the diagnosis and treatment decision making process.

4. Management of the Axilla

4.1 All patients diagnosed with breast cancer should have a pre treatment ultrasound evaluation of the axilla.

4.2 If abnormal axillary lymph nodes are identified an ultrasound guided biopsy should be performed.

4.3 If the axilla is clinically and radiologically negative offer sentinel lymph node biopsy (SLNB) as the standard staging treatment of the axilla.

4.4 If involved axillary lymph nodes are detected preoperatively, offer axillary lymph node clearance or consider neo-adjuvant chemotherapy (refer to guidelines for non-surgical treatment at: http://www.birminghamcancer.nhs.uk/uploads/document_file/document/4dee1d30358e981f1c000385/guidelines_breast_non_surgical_treatment_version_3.pdf).

4.5 Patients diagnosed with DCIS should not routinely undergo SLNB.

4.6 Consider SLNB with a diagnosis of DCIS if the patient is having a mastectomy, or if there is a palpable lump or mass lesion on imaging.

4.7 Consider SLNB prior to reconstructive procedures.

4.8 Full axillary lymph node clearance should contain >10 lymph nodes in 90% of patients (target 100%).

4.9 Breast units should audit their rates of axillary recurrence.

5. Sentinel Lymph Node Biopsy (SLNB)

5.1 SLNB should now be considered as the standard surgical staging procedure for the clinically and radiologically uninvolved axilla to reduce morbidity from axillary surgery.

5.2 The routine use of axillary lymph node clearance will be over treatment for the majority of patients.

5.3 Isotope and blue dye should be used routinely. Local protocols should be used.

5.4 If the sentinel node is positive (macro and micrometastasis) further axillary treatment should be offered with axillary node clearance or radiotherapy.

5.5 Peri operative sentinel lymph node assessment may be available locally (OSNA 'One Step Nucleic Acid Amplification', imprint etc). This allows progression to axillary dissection as a single procedure if the sentinel lymph node is found to be positive. Local audits of this should be undertaken if this technique is used.

5.6 The significance of isolated tumour cells (ITC's) is currently uncertain and the node should be regarded as negative for treatment purposes.

6. Reconstruction

6.1 For guidance on reconstruction please refer to the following document:

"Guideline for the management of patients suitable for immediate breast reconstruction" 2011, Pan Birmingham Cancer Network.
http://www.birminghamcancer.nhs.uk/uploads/document_file/document/4e414cbc358e985c8a000cee/guideline_for_the_management_of_patients_suitable_for_breast_reconstruction_version_3.0.pdf

7. Surgery in Locally Recurrent Disease

7.1 The management of each patient with local recurrence should be discussed by the breast cancer MDT.

7.2 Patients with locally recurrent disease should be restaged radiologically. CT and bone scan to look for coexistent metastatic disease should be considered.

7.3 Any combination of the major therapeutic modalities including surgery, radiotherapy and systemic treatment may be appropriate. Optimum treatment will depend on various factors including previous treatment, the patient's general fitness, the site and extent of the recurrence and tumour characteristic.

8. Patient Information and Counselling

8.1 All patients, and with their consent, their partners will be given access to appropriate written information during their investigation and treatment, and on diagnosis will be given the opportunity to discuss their management with a clinical nurse specialist who is a member of the relevant MDT. The patient should have a method of access to the breast team at all times.

8.2 Access to psychological support will be available if required. All patients should undergo a holistic needs assessment and onward referral as required.

9. Palliative Care

9.1 Palliative care services will be made available to all patients as deemed appropriate by the MDT.

10. Clinical Trials

10.1 Wherever possible, patients who are eligible should be offered the opportunity to participate in National Institute for Health Research portfolio clinical trials and other well designed studies.

10.2 Where a study is only open at one Trust in the Network, patients should be referred for trial entry. A list of studies available at each Trust is available from Pan Birmingham Cancer Research Network. Email: PBCRN@westmidlands.nhs.uk .

10.3 Patients who have been recruited into a clinical trial will be followed up as defined in the protocol.

References

1. NICE 2009, *Early and locally advanced Breast Cancer: diagnosis and treatment.* NICE clinical guideline 80.
2. Department of Health, 2004, *Manual for Cancer Services 2004.* Department of Health, London.
3. Surgical guidelines for the management of breast cancer, Association of breast surgery at BASO 2009, EJSO(2009); S1 - S22
4. Peer review standards 2B
5. West Midlands Cancer Intelligence Unit (WMCIU)

Authors of Versions 1 and 2

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Monitoring of the Guideline

Implementation of the guidance will be considered as a topic for audit by the NSSG in 2014.

Approval Signatures

Pan Birmingham Cancer Network Governance Committee Chair

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Signature  Date November 2011

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