Breast Cancer Regional Follow-up Guidelines Review

The purpose of the breast cancer regional follow-up guidelines is to ensure consistency of practice across the West of Scotland and the principles of any revision to the follow-up guideline will continue to ensure that management of patients after initial treatment for breast cancer is:

- Patient-centred;
- Aligned to recognised current best practice;
- Equitable across the region;
- Clinically safe and effective; and
- Efficiently delivered.

The guidelines continue to be developed on the basis that the key aims underpinning the purpose of follow-up are to:

- Manage and treat symptoms and complications;
- Provide psychological and supportive care;
- Support and motivate patients to continue endocrine therapy;
- Encourage healthy lifestyle habits; and
- Detect and treat recurrent and new disease.

Follow-up practice has to be patient centred and ideally, supported by empirical evidence of improved outcomes and survival. In the absence of good quality evidence, care should be tailored to the needs and preference of patients. The construction of appropriate follow-up guidance requires balancing perceived patient needs with effective utilisation of resources.

A review of the existing regional breast cancer guidelines commenced in January 2017, led by Miss Jenny McIlhenny, Consultant Oncoplastic Breast Surgeon, NHS Forth Valley and Ms Iona Reid, Consultant Breast Surgeon, NHS Greater Glasgow and Clyde and Clinical Lead of the Breast MCN.

Alternative models of follow up and the evidence supporting these were presented and discussed at the Breast MCN Regional Education Event in November 2016. A review of evidence and guidance on the management of follow-up was undertaken and the West of Scotland Breast Cancer MCN guidelines have been updated to reflect contemporary practice.

These regional guidelines are recommended by the Breast Cancer MCN whose members also recognise that specific needs of individual patients may require to be met by an alternative approach and that this will be provided where necessary and documented in the patient notes.

Transitional arrangements from previous follow up can be made: either continue with previous model for patients currently in follow up; or transfer to new model where appropriate.

**Main changes from previous guideline:**

- No requirement for annual questionnaire to form part of follow up
- Formal review of endocrine therapy at 5 years in patient-led follow up
- Mammography beyond 5 years in the over-50 population can be delivered every 3 years via the Breast Screening programme.
Breast Cancer Follow Up Guidelines

West of Scotland Breast MCN - Regional Consensus Guideline
This consensus guideline should be used as a minimum standard, for the majority of patients, when considering local implementation.

Common Pathway after Surgery/Chemotherapy/Radiotherapy Treatment

- On completion of initial treatment i.e. surgery/radiotherapy (whichever occurs last) patients will have an ‘Exit Interview’ carried out by a member of the breast team: Consultant; Specialty Doctor; or Clinical Nurse Specialist (CNS).

At this interview:
- Patients to be given a copy of their diagnosis and treatment summary - this should be copied to the GP. This should be based upon the National Cancer Survivorship Initiative Treatment Summary (appendix 1);
- Advice about specific lifestyle recommendations: weight loss/dietary advice; alcohol intake; physical activity; and smoking cessation;
- Resource information for the above;
- Contact details for the breast CNS and local support groups;
- Reassurance they can contact breast CNS with any concerns; and
- Where possible patients should be offered a Holistic Needs Assessment during or after treatment. It is anticipated that this would be led by the breast CNS, but could be performed by any member of the clinical team according to local arrangements.

Outpatient follow up

- Routine annual (or more frequent) outpatient appointments need not be given;
- Routine clinical breast examination has not been shown to be clinically effective and need not be performed;
- Units may still choose to use regular outpatient appointments but it is anticipated this would be as a means to deliver mammography, DXA and endocrine therapy review; and
- Regular outpatient appointments may be appropriate in a small proportion of patients: those with learning difficulties; dementia; or in other specific cases; and this requirement should be identified at the MDT or exit interview.

Mammography

- Annual mammogram to 5 years or to age 50 whichever occurs last; i.e. if patient is under 50 at year 5 they should continue with annual mammograms until they turn 50;
- Mammography beyond 5 years in the over 50s can be delivered every 3 years through the National Screening Programme;
- For those over 70 at 5 years postop, further mammograms can be carried out via the National Screening Programme on patient request as with the general population; and
- Patients in gene carrier/higher risk family history groups should continue with imaging as recommended by Scottish surveillance guidelines.

Endocrine treatment

- Patients on endocrine treatment should have a review of their treatment at 5 years. This may be performed at an outpatient appointment or in an MDT setting, with written advice to patient and GP.

DXA

- Patients taking bisphosphonates (e.g. Ibandronate) do not require regular DXA; and
- Baseline and biennial DXA should be arranged and results reviewed for patients taking aromatase inhibitors without high dose bisphosphonates.
Requirements for all models of follow up:

- Safe IT recall systems;
- Ready access to breast CNS;
- Robust access back into the breast service via the breast CNS;
- Available clinic slots for rapid access: can be triaged to clinics with or without instant imaging; and
- Breast MCN longer term recommendation is for a new I.T. recall system with associated technical and administrative support on an ongoing basis.

Supporting Documentation

- Treatment Summary;
- Holistic Needs Assessment;
- Consider appropriate point of contact if patient is in a care home setting;
- Guidance on lifestyle recommendations;
- Checklist of signs and symptoms and what to do about them: e.g. the ‘Moving Forward’ Pack from Breast Cancer Care/Macmillan Literature;
- Contact details for rapid access back into the breast service; and
- Contact details for local support services.

DNA Protocol

Patients failing to attend for imaging should be flagged back to the clinical team for action as per existing local arrangements.
Appendix 1
Treatement Summary Template (Adapted from National Cancer Survivorship Initiative)

Dear Patient x

cc General Practitioner

Re: Patient name, address, CHI
This patient has now completed their initial treatment for breast cancer and a summary of their diagnosis, treatment and ongoing management plan is outlined below. The patient has a copy of this summary.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Date of diagnosis</th>
<th>Staging Local/Distant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of Treatment and relevant dates</td>
<td></td>
<td>Treatment aim</td>
</tr>
<tr>
<td>Possible treatment toxicities and/or late effects</td>
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<td></td>
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<tr>
<td>Alert Symptoms that require referral back to specialist team</td>
<td>Contacts for referrals or queries</td>
<td>In Hours</td>
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<tr>
<td>Secondary Care Ongoing Management Plan (tests, appointments etc)</td>
<td>Other service referrals made: (delete as necessary)</td>
<td>District Nurse</td>
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<td></td>
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<td>Social Worker</td>
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<td>Dietician</td>
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<td>Clinical Nurse Specialist</td>
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<td>Psychologist</td>
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<td>Benefits/Advice Service</td>
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<td>Other</td>
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<tr>
<td>Required GP actions (eg ongoing medication)</td>
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<tr>
<td>Summary of information given to the patient about their cancer and future progress</td>
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<tr>
<td>Additional information including issues relating to lifestyle and support needs</td>
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<tr>
<td>Completing Doctor/CNS:</td>
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<td>Date</td>
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</tbody>
</table>

West of Scotland Cancer Network
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