Optimal care pathway for women with breast cancer

Quick reference guide

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

**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:**

- 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 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.

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

**Treatment summary**
- 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**
- 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:**
- discuss treatment options with the woman/carer including the intent of treatment and expected outcomes
- discuss the treatment plan with the woman's GP.
- 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.
- explain the treatment intent, likely outcomes and side effects to the woman/carer
- initiate a discussion regarding advance care planning if appropriate.
- 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.

**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.

**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.

**Chemotherapy and other systemic therapy:** Chemotherapy or drug therapy may be appropriate as neoadjuvant or adjuvant treatment.


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