### Version Control

This is a controlled document please destroy all previous versions on receipt of a new version.

**Date Issued: May 2013**  **Review Date March 2015**

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<th>Date Issued</th>
<th>Review Date</th>
<th>Brief Summary of Change</th>
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<td>March 2004</td>
<td>July 2007</td>
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<td>Breast NSSG</td>
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<td>2.0</td>
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<td>May 2009</td>
<td>Update in line with recommendations in IOG</td>
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<td>September 2009</td>
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<td>3.2</td>
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<td>October 2009</td>
<td>Final version – imaging to be updated</td>
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<td>3.3</td>
<td>October 2009</td>
<td>October 2009</td>
<td>Final version after consultation – imaging to be updated</td>
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<td>3.4</td>
<td>October 2009</td>
<td>April 2010</td>
<td>Changes made after October NSSG</td>
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<td>3.5</td>
<td>April 2010</td>
<td>January 2011</td>
<td>Imaging Guidelines Added Regimens appendix amended / website link added</td>
<td>Breast NSSG</td>
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<tr>
<td>3.6</td>
<td>January 2011</td>
<td>April 2011</td>
<td>Reviewed Follow up guidelines / referral guidelines following Peer Review 2010</td>
<td>Breast NSSG</td>
</tr>
<tr>
<td>3.6</td>
<td>April 2011</td>
<td>April 2013</td>
<td>Updated following NSSG guidelines meetings in March 2011, further changes to be agreed at NSSG</td>
<td>Breast NSSG</td>
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<tr>
<td>3.7</td>
<td>February 2013</td>
<td></td>
<td>Guidelines reviewed by the group. Algorithms amended</td>
<td>Breast CEG</td>
</tr>
<tr>
<td>3.8</td>
<td>May 2013</td>
<td>March 2015</td>
<td>Guidelines reviewed by the group. Changes made to the MDT configuration. Follow up arrangements revised. Amendments made to adjuvant chemotherapy Recent NICE guidance incorporated. Amendments made to indications for tumour boost treatment in light of latest evidence.</td>
<td>Breast CEG</td>
</tr>
<tr>
<td>3.8a</td>
<td>January 2014</td>
<td>March 2015</td>
<td>Changes from PTCs to CCGs, Changes to catchment population Reformatted guidelines, Deleted links to duplicate guidelines</td>
<td>Breast CEG</td>
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For the latest version of these guidelines please see the NEYHCA (Cancer) website  
Please press control and click on the link below:

http://www.hyccn.nhs.uk/NetworkGuidelinesAndPublications/BreastNSSG.htm
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Foreword

A guideline is “not a rigid constraint on clinical practice, but a concept of good practice against which the needs of the individual patient can be considered.” (RCR 1990)

It remains the responsibility of the practising Clinicians to interpret the application of guidelines, taking into account local service constraints and the needs and wishes of the patients.

In reviewing the summary guidelines, local clinicians and managers will be required to assess whether the guidance can be met; and if not, what service developments need to be undertaken to achieve the ‘ideal service’ as defined by the available evidence.

Objectives & Methodology

The Manual for Cancer Services states that the Clinical Expert Group should agree clinical and referral guidelines. Guidelines define structure, process and standards against which the development and quality of the service can be assessed through audit. They also allow the service to be reviewed against the ideal, in order to direct effective service development and investment, and ensure seamless care is delivered and maintained between primary, secondary and tertiary sectors.

The Calman-Hine report recommends that GPs, Cancer Units and Cancer Centres should agree upon guidelines. Guidelines define structure, process and standards against which the development and quality of the service can be assessed through audit. They also allow the service to be reviewed against the ideal, in order to direct effective service development and investment, and ensure seamless care is delivered and maintained between primary, secondary and tertiary sectors.

Breast cancer is the most common cancer in the UK despite the fact that it is rare in men. In 2008, there were 48,034 new cases of breast cancer diagnosed in the UK: 47,693 (over 99%) in women and 341 (less than 1%) in men. Breast Cancer UK – please press control and click on the following link:

http://info.cancerresearchuk.org/cancerstats/types/breast/incidence/

Of these new cases, a small proportion are diagnosed in the advanced stages, when the tumour has spread significantly within the breast or to other organs of the body.

In addition, a significant number of women who have been previously treated with curative intent subsequently develop either a local recurrence or metastases.

Risk Factors & Epidemiology

Lifetime risk
Breast cancer is by far the commonest cancer in women in the UK accounting for 31% of all cases in women. The next most common cancer in women is lung cancer, with 17,960 cases (12% of total) in 2008. So nearly a third of all new cancers in women are breast cancers. It has been estimated that the lifetime risk of developing breast cancer is 1 in 1,014 for men and 1 in 8 for women in the UK.¹

By age
Breast cancer risk is strongly related to age, with 81% of cases occurring in women aged 50 years and over. Nearly half (48%) of cases of breast cancer are diagnosed in the 50-69 age groups (Figure 1.1): these women and those aged 70 are targeted in the national screening programme. In 2006, the NHS Breast Screening Programme announced its intention to extend the age range of women eligible for breast screening to ages 47 to 73. The extension which is being carried out as a randomised trial is due to be completed by 2018

3. Welsh Cancer Intelligence and Surveillance Unit. Cancer Incidence in Wales, 2010

Figure 1.1: Breast Cancer (C50), Number of New Cases and Age-Specific Incidence Rates, UK, 2008

Breast cancer UK – please press control and click on the following link: http://info.cancerresearchuk.org/cancerstats/types/breast/incidence/

Socio-economic variations
Breast cancer is one of the few cancers where incidence rates are higher for more affluent women and there is a clear trend of decreasing rates from least to most deprived groups. An analysis of incidence rates in Scotland for patients registered from 2001-2005 showed a 6% difference between the rates in the least deprived (EASR 118.7 per 100,000) and the most deprived (EASR 111.0 per 100,000) areas.

2. ISD Scotland Breast cancer 2009

In 2008 it was estimated that worldwide, 1.38 million women were diagnosed with breast cancer, accounting for around a tenth (10.9%) of all new cancers and nearly a quarter (23%) of all female cancer cases. Female breast cancer incidence rates vary considerably, with the highest rates in Europe and the lowest rates in Africa and Asia (Figure 1.2).

**Screening**

The effect of the introduction of the National Health Service Breast Screening Programme (NHSBSP) in England was to increase detection and so increase the age specific rates amongst the screened groups. This explains only some of the observed increase, and only towards the start of this period. The underlying increase predates national screening and is strongest in older age groups (Coleman, 2000). There is some evidence that the underlying incidence rate of breast cancer may be stabilising (Sant et al.2006).

**Prognosis**

Breast Cancer Clinical Outcome Measures’ (BCCOM) audit (2007) of more than 16,000 cancers diagnosed in 2004 found that the majority of symptomatic cancers were invasive. Where Nottingham Prognostic Index was known tumours were classified into 6 prognostic groups. 51% fell into the three most favourable prognostic groups (excellent, good or moderate). This contrasts with 83% of screen detected tumours that fall into the same three groups.

**Mortality**

In 2006 there were 12,392 deaths in the UK caused by breast cancer of which all but 73 were amongst women. Overall these account for more than 1 in 6 of all cancer deaths in women, making it the second most frequent cause of cancer death in women (after lung cancer). Across the UK the European age-standardised mortality rate is 27.7 per 100,000. Female age-specific mortality rates increase sharply after the age of 40 years, peaking at almost 300 per 100,000 in those aged over 85 years (ONS, 2008; Welsh Cancer Intelligence and Surveillance Unit, 2008; Information and Statistics Division NHS Scotland, 2008; Northern Ireland Cancer Registry, 2008).

**Survival**

The overall five-year survival for women diagnosed in 2001-2003 was 80%, as recently as the early 1990s it was less than 70%. In the late 1970s five-year survival was less than 60%. This trend is attributed to the recommendations arising from the 1984-85 world overview of systemic therapy (Early Breast Cancer Trialists’ Collaborative Group, 2005).

Survival also varies by staging at time of diagnosis. For women in the West Midlands diagnosed in the late 1980s, actual ten-year survival varied from almost 80% for stage I tumours to less than 5% for stage IV (Cancer Research UK, 2007).
The above sections prognosis, mortality & survival are from the NICE 2009 Guidance. For more details please see the NICE Website (press control & click on the link below)
www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7168

NEYHCA Incidence & Survival Rates

<table>
<thead>
<tr>
<th>Measure</th>
<th>England</th>
<th>HYCCN</th>
<th>NHS Hull</th>
<th>NEL CTP</th>
<th>NHS NL</th>
<th>NHS NYY</th>
<th>NHS ERY</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence ASR (2006-08)</td>
<td>124.0</td>
<td>120.5</td>
<td>121.2</td>
<td>109.6</td>
<td>117.0</td>
<td>121.5</td>
<td>130.4</td>
<td>HYCCN has 7th lowest incidence in all networks; NEL in 10% of PCTs with lowest incidence rate.</td>
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<tr>
<td>Mortality ASR (2006-08)</td>
<td>26.7</td>
<td>29.1</td>
<td>33.2</td>
<td>23.8</td>
<td>32.3</td>
<td>27.1</td>
<td>27.3</td>
<td>Network rate is the highest in the country; Hull mortality rate is the highest in the country with Hull and NL in 10% of all PCTs with highest mortality rate</td>
</tr>
<tr>
<td>One year relative survival (2003-07)</td>
<td>96.7</td>
<td>96.2</td>
<td>96.3</td>
<td>96.1</td>
<td>96.3</td>
<td>97.1</td>
<td>97.0</td>
<td>HYCCN 7th highest survival rate in all networks; NY and ERY figure in 10% PCTs with highest survival</td>
</tr>
<tr>
<td>Five year relative survival (1999-2003)</td>
<td>82.7</td>
<td>82.0</td>
<td>82.2</td>
<td>81.0</td>
<td>81.5</td>
<td>85.0</td>
<td>82.2</td>
<td>NY in quintile of PCTs with highest survival</td>
</tr>
</tbody>
</table>

Source: National Cancer Information Service (NCIS) extracted 2010

Audit & Research

A network audit project is related to the cancer site or sites of the CEG and the activities of its Specialist & Local Multidisciplinary Teams (SMDT / LMDTs) within that network (In our case formerly the Humber and Yorkshire Coast Cancer Network HYCCN, now the North East Yorkshire & Humber Clinical Alliance, NEYHCA).

The same audit project should be carried out by all MDTs for that cancer site in the network, each team's results being separately identified.

The minimum progress needed for the CEG's compliance is that the CEG, in consultation with the MDTs, agrees at least one network audit project with the network board, with any necessary sources of funding agreed with commissioners or from elsewhere.

The individual MDTs for compliance with this measure should agree to participate in the audit.

As the Breast CEG deals with MDTs of more than one level of specialisation each individual MDT may not have the same role in the audit or be able to participate in all its aspects.

The MDT should annually review the progress of the project or present the results of the completed network audit project to the CEG for discussion at one of their meetings

Audit

All units should have policies or guidelines for care, with the guidelines developed through consultation between Cancer Units and Cancer Centres. These guidelines will form the basis for audit and evidence of relevant data collection should be demonstrated. The main issues to monitor include clinical throughput, morbidity, pathology and monitoring of outcomes.
The results will then be used to evaluate implementation of these guidelines and identify problem areas where further education and/or resources need to be targeted.

- Audit should take place across the entire service delivery network, including the Cancer Centre and all related Units.
- Each trust in turn would co-ordinate network wide audits
- The CEG & MDT should annually review the progress of the project or present the results of the completed network audit project to the CEG for discussion at one of their meetings
- All members of the multidisciplinary teams should attend regular audit meetings.
- The results of the network audit should be presented at regional and national meetings.

Research
The Manual for Cancer Services 2008 states that cancer sites which have standards based on Improving Outcomes Guidance (IOG), the parameters to be audited should be drawn from the “Measurement” sections of the relevant IOG.

Cancer Centres/Units should be encouraged to participate in surgical and non-surgical randomised controlled trials, particularly national trials. Primary Care Trusts (PCTs) should endeavour to secure the provision of additional resources needed to participate in clinical trials.

- There should be a single network list of clinical trials and/or studies into which the Multidisciplinary Teams (MDTs) should give priority for patient entry.
- The CEG should regularly receive written reports regarding accrual of patients into trials and at least annually should receive and discuss a report from each of the MDTs in response to the CEG approved trials list.
- Any remedial actions required following these reports should be agreed by the CEG, MDT and the Clinical Lead for the Research Network.
- A minimum dataset should be agreed across the Cancer Network. A data manager/MDT Coordinator should be employed to collect the agreed Network minimum dataset. A record of all patients with known or suspected Breast conditions should be kept.
- The MDS should include the data items required for:
  - The cancer waiting times monitoring, including Going Further on Cancer Waits, in accordance with DSCN 20/2008, to the specified timetable as specified in the National Contract for Acute Services;
  - The Cancer Registration Dataset as specified in the National Contract for Acute Services.

All items required for the national contract, any additional items should use definitions and codes taken from the National Cancer Dataset and the NHS Data Dictionary.

- The MDT records the MDS or their portion of the MDS for each patient on proformas and/or in an electronically retrievable form.
- The CEG should agree with the MDT a network-wide policy specifying:
  - Which team members should collect which portion of the MDS;
  - When each data item should be captured on the patient pathway;
  - How the data will be stored and managed within all appropriate local data systems.
1. General Principles of Care

- Patients should be managed by a multidisciplinary team in a designated breast unit, which treats more than 100 new cases per year.
- Patients should be informed of the different treatment options (including no treatment) and should be involved in the decision making process to the extent that they wish.
- All women should have access to a breast care nurse at all stages of their illness.
- All professionals should be alert to the development of psychological and psychiatric problems in either the patient or their family members and guide them to seeking help. Patients should be offered prompt access to specialist psychological support and, if appropriate psychiatric services
- Patients with young families should be offered support from a specialist social worker
- Patients should be encouraged to enter clinical trials.
- Core members of the MDT with direct clinical contact should have attended the National Advanced Communication Skills training course.
- All core MDT members should have 50% of their contracted direct clinical care time devoted to breast cancer

1.1 Referral Guidelines

Patients are referred to the Breast Clinic by:
1. GPs either through the 2 week wait referral system or by standard referral.
2. Other consultants
3. Other cancer MDTs
4. The screening programme.
5. CNS’s

Patients should receive an advice sheet on what to expect prior to their first appointment

1.2 Urgent Referral through the two week-wait system

- Any patient who had previously had histologically confirmed breast cancer who presents with a further lump or suspicious symptoms
- Women aged 30 or over with a discrete lump in the breast that persists after her next period or presents after menopause.
- Woman aged under 30:
  o With a lump that enlarges
  o In whom there are other reasons for concern such as significant family history
- A man aged 50 or over with a unilateral, firm sub areolar mass with or without nipple distortion or associated skin changes
- Patients, including those under 30, with other breast signs or symptoms which are highly suggestive of cancer. These include:
  o Discrete hard lump with fixation with or without skin tethering
  o Ulceration
  o Skin distortion
  o Recent nipple retraction or distortion or suspected Paget’s disease
  o Spontaneous unilateral bloody nipple discharge
1.3 Conditions that require standard referral, not necessarily urgent:

- Discrete lump in a younger woman (age < 30 years) who do not meet the two week wait criteria.
- Asymmetrical nodularity that persists at review after menstruation
- Abscess
- Persistently refilling or recurrent cyst
- Intractable pain which does not respond to simple measures.
- Nipple discharge:
  - Bilateral discharge sufficient to stain clothes in patients aged < 50 years.
  - Any nipple discharge in patients over 50 years of age

The appropriateness of referrals against the agreed referral criteria will be audited, with feedback for GPs and PCTs. The number of patients referred as urgent, the proportion of urgent referrals who are subsequently found to have cancer, and the numbers of routine referrals who are found to have cancer will also be monitored. This is important in order to detect the need for any change in the referral policy.

Trusts should aim to see all patients within the nationally agreed waiting times. However, if this is not possible additional capacity should be sought.

In patients presenting with symptoms and/or signs suggestive of breast cancer investigation prior to referral is not recommended.

1.31 Booked Appointments

The Government’s target is that patients can book their admission / appointment at three key stages:

- First specialist appointment
- First diagnostic investigation
- First definitive treatment

1.4 Secondary to Secondary Referral

Secondary to Secondary referrals, e.g. NLGHFT to HEYHT or Local MDT to Specialist MDT or referral to another specialty – e.g. Lung, involves the following procedure:

**Breast LMDT to Breast SMDT**

There is one Specialist MDT within NEYHCA for Breast Cancer. This is based at Castle Hill Hospital in Hull.

Patients who need to be discussed at this Specialist MDT, whether they are from within the Network or from a surrounding Network, should be referred for discussion at the MDT based at Hull & East Yorkshire Hospitals NHS Trust.

Any referrals to this SMDT should be made by a faxed referral letter or copy of the referring Unit’s completed MDT proforma to:

Breast MDT Co-ordinator  
Tel: 01482 875875 Ext 3607  
Fax: 01482 675505
The MDT co-ordinator will add the patient to the Breast MDT for discussion and highlight these referrals to the MDT lead.

The MDT Lead is responsible for ensuring these patients are discussed at the Specialist MDT.

**Breast MDT to another specialty**
The same procedure applies, but the MDT coordinator for that specialty should be contacted.

In all instances the normal Inter Hospital Transfer (IHT) policy should be adhered to.

**Secondary to Secondary Referral Follow Up**
Follow up will normally be carried out by the referring hospital, but this will be discussed by the Specialist MDT and recommendations made by them to the referring clinician.

### 1.5 Key contact numbers for all Trusts

<table>
<thead>
<tr>
<th>Hospital / MDT coordinator</th>
<th>Fax Number</th>
<th>CNS</th>
<th>Lead Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hull and East Yorkshire Hospitals NHS Trust Cancer Centre / Unit Tracey Boyce 01482 622674</td>
<td>Urgent Referral to be faxed 01482 675505</td>
<td>Ms Chris Batty Ms Terry Jemison Ms Jane Jenkinson Ms Philippa Robinson Ms Pam Hoyles 01482 622013</td>
<td>Miss Penny McManus Sec Elaine French Ext 01482 624238 Fax 01482 622650</td>
</tr>
<tr>
<td>York Teaching Hospitals NHS Trust (Scarborough) Cancer Unit (LMDT – linked with York) ???? 01723 385292 Allison Meads 01723 385175</td>
<td>Urgent Referral to be faxed 01723 342423</td>
<td>Mrs Sue Baker Mrs Sue Ledden Mrs Andrea Ward Bleep Switchboard 01723 368111</td>
<td>Mr Ben Mancey-Jones</td>
</tr>
<tr>
<td>North Lincolnshire &amp; Goole Hospitals Foundation Trust Cancer Unit (LMDT) Natalie Castle/ Cathie Birk 01472 874111 Extn 7044</td>
<td>Urgent Referral to be faxed Grimsby 01472 302325 Scunthorpe (Refer via DPOW number above)</td>
<td>Ms Ann Thorne Ms Barbara Chaplin Ms Gill Dunthorne Grimsby 01472 874111 Ext 7729 and 2385 Ms Maxine Woollin Ms Lisa Hall Scunthorpe 01724 282282</td>
<td>Miss Jenny Smith Sec Denise Bygott Ext 01472 875701 Ex 1210</td>
</tr>
</tbody>
</table>
2. Assessment & Diagnosis

Patient should only be seen by medical and clinical practitioners with a special interest in breast disease or supervised trainees.

All clinicians / practitioners should attend nationally approved courses relating to good practice.

The clinic visit should be based upon the clinical history and examination findings. A discrete lump is investigated on the bases of “triple assessment.”

2.1 Triple Assessment

- The clinical findings from a relevant history and physical examination
- Breast Imaging using mammography + or - ultrasound
- Pathological assessment with histology (by core biopsy) or cytology (by fine needle aspiration)

The target is to carry out all these investigations at the first clinic visit and the results should be available within 5 working days.

There should be access to a family history clinic linked to the Regional Clinical Genetics Service.

Relevant background clinical information and the patient’s preferences should be considered.

Following presentation of the results of the Fibroadenoma audit, it was agreed that young women aged 25 or less presenting with typically benign lesions clinically and who demonstrate benign ultrasound findings, U2, as per the modified Stavros criteria used in the audit will no longer need histology / cytology

**ULTRASOUND DIAGNOSIS OF FIBROADENOMAS MODIFIED STAVROS CRITERIA**

<table>
<thead>
<tr>
<th>MALIGNANT (U4, U5)</th>
<th>BENIGN (U2)</th>
<th>INDETERMINATE (U3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiculation</td>
<td>Absent Malignant findings</td>
<td>Maximum Diameter &gt;3cm</td>
</tr>
<tr>
<td>Angular Margin</td>
<td>Intense hyper-echogenicity</td>
<td>Isoechnogenicity</td>
</tr>
<tr>
<td>Marked Hypo-echogenicity</td>
<td>Ellipsoid Shape</td>
<td>Mild hypo-echnogenicity</td>
</tr>
<tr>
<td>Shadowing</td>
<td>Gentle bi/trilobulation</td>
<td>Normal sound transmission</td>
</tr>
<tr>
<td>Calcification</td>
<td>Thin echogenic pseudocapsule</td>
<td>Enhanced sound transmission</td>
</tr>
<tr>
<td>Duct extension</td>
<td>Benign Doppler pattern</td>
<td>Heterogeneous texture</td>
</tr>
<tr>
<td>Branch Pattern</td>
<td></td>
<td>Homogeneous texture</td>
</tr>
<tr>
<td>Microlobulation</td>
<td></td>
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</tr>
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Any patients with clinical /imaging discrepancy should proceed to sampling. This does not apply to women with a known raised family history risk of breast cancer, or women who have previously already been diagnosed with a cancer.
This in line with recent evidence from the literature and recent publication on diagnosis of women with breast symptoms published in Nov 2010 by Department of Health and Breakthrough Breast Cancer.

http://www.breakthrough.org.uk

2.2 Imaging

Imaging should be performed as per the agreed Network Imaging Guidelines.

New Female Patients

1. Women under 35
   • Imaging is not routinely indicated.
   • Ultrasound should be performed if clinical examination indicates a focal breast problem.
   • If malignancy is suspected on ultrasound or clinical examination then mammography should be performed prior to biopsy.

   Imaging is not indicated for breast pain / tenderness / benign nodularity.

2. 35-40 years
   • As above, plus mammography for focal breast problems at the discretion of the responsible clinician (if the patient has not had mammography in the last year).
   Exceptions: Patient pregnant or lactating, painful periductal mastitis, or breast abscess.
   • In women with implants and little breast tissue ultrasound may be used without prior mammography if clinically indicated.

3. 40 - 50 years
   • Mammography is routinely indicated as the occurrence of screen detectable incidental breast cancer is 15 per 1000 women by aged 50 years increasing rapidly with age
   Exceptions: Patient is pregnant or lactating, painful periductal mastitis, or breast abscess.
   • Ultrasound should be performed as 2\textsuperscript{nd} line investigation for any focal clinical or mammographic abnormality.

4. 50 – 75 years
   • Mammography is routinely indicated if the patient has not been imaged by mammography within the last 12 months.
   • Ultrasound should be performed as 2\textsuperscript{nd} line investigation for any focal clinical or mammographic abnormality.

5. Over 75 years
   • Mammography and ultrasound should be used to investigate any focal clinical abnormality unless the clinician deems this clinically inappropriate (e.g. large fungating lesion, immobility)
   • In patients with a clinically normal breast, routine mammography should be taken as a clinical decision depending on overall general health of the patient
The Axilla

- All imaged suspected breast cancers should have the axilla scanned by ultrasound & sampling of any suspicious lymph nodes visualised.
- Suspicious lymph nodes in the axilla in the absence of any breast lesion should have core biopsy, followed by MR of the breast if histology suggests a breast primary.

New Male Patients

1. Under 30 years
   - No imaging is routinely indicated for clinical gynaecomastia.
   - Ultrasound should be performed for focal lumps not beneath the nipple
   - Ultrasound should be performed for a lump on chest wall or axilla

2. 30 – 50 years
   - Ultrasound if clinically atypical.
   - Mammography if features of malignancy are seen on ultrasound prior to biopsy.

3. 50 years+
   - Mammography routinely
   - Ultrasound should be performed for any focal abnormality shown on mammography or clear or blood stained nipple discharge.

GP & non breast specialist referrals

In accordance with RCR Guidance direct imaging referrals for mammography and Breast Ultrasound from GPs / non breast specialists to a Breast Unit should not be accepted. These should either be returned to the GP/non breast specialist for redirection with an explanatory letter. (See reference 4 below)

Incidental Breast lesions discovered on imaging for other reasons should be referred to the Breast MDT.

Family History / other high risk – see NICE guidelines
http://guidance.nice.org.uk/CG41
http://www.rcrbreastgroup.com/Members/BreastGroup/HDScreeninginfo.php

MRI: To be agreed at prior MDT discussion.

- Lobular carcinomas.
- Mammographically occult lesions.
- Discrepancy in size (Mammography / ultrasound / clinical).
- Suspected multifocal disease
- Patients for neoadjuvant chemotherapy treatment.

Monitoring of neoadjuvant therapy see full guidelines Chapter 4.

References

1. RCR 2003: Guidance on Screening and Symptomatic Breast Imaging 2nd Edition
2. NICE guidance on Familial Breast Cancer October 2006 (to be reviewed 2010)
http://guidance.nice.org.uk/CG41
3. RCR Breast Group Hodgkins screening leaflet
http://www.rcrbreastgroup.com/Members/BreastGroup/HDScreeninginfo.php
4. RCR 2000: Guide to Justification for Clinical Radiologists

The Network Imaging Group guidelines can also be found on the NEYHCA website
www.hyccn.nhs.uk/NetworkGuidelinesAndPublications/NetworkImagingGroup.htm
2.3 Pathology

Histological confirmation should be sought for each lesion. Pathology should be performed in accordance with the Royal College of Pathologists Guidelines.

The CEG have agreed Pathology guidelines for the diagnosis and assessment of the cancer site or sites of the group. The guidelines will address:

- Laboratory and histopathological / histochemical investigations;
- Their specific indications.

All specimens should be handled and recorded in accordance with the guidelines contained in the document, Pathology Reporting of Breast Disease: NHSBSP Publication No. 58 published in January 2005 and the Royal College of Pathologists’ Minimum Dataset for Breast Cancer Histopathology 2nd Edition.

The guidelines can be found on the Royal college of Pathologists website (RCPath Breast Cancer histopathology dataset report. RCP – Jan 2005, amended October 2005)


Soft tissue pathway for breast cancer was published by the RCP in April 2009


- Histological confirmation should be sought for every lesion. There should be pre-operative histological confirmation of the diagnosis and postoperative gross and microscopic assessment of the resected specimen.

- The resection specimens should be sampled in order to confirm or establish the histological diagnosis and to provide prognostic information. The prognostic information should include all of the items detailed in the National Dataset for Breast Cancer. This will also fulfil the requirements of the cancer registries. In addition, additional data items may be collected as part of local quality control, audit and research initiatives.

- Each Cancer Unit should have identified a Pathologist to whom they refer difficult histopathology specimens for a second opinion.

- Histopathologists reporting cancers should participate in appropriate EQA schemes.

- Histopathology laboratories nominate a lead pathologist for each of the main cancers with responsibility for liaising with relevant local committees and clinicians and ensuring that the relevant cancers are examined, sampled and reported appropriately and in a consistent fashion.

- Cancer Centers and Units should be supported only by laboratories accredited to the standards of Clinical Pathology Accreditation (UK) Ltd, and staffed in accordance with the recommendations of The Royal College of Pathologists and the Association of Clinical Pathologists.
• All cancer networks should have easy access to appropriate immunophenotypic, molecular biological and cytogenetic facilities. Some of the latter are very specialised pathology services and may not be provided by pathology laboratories within the LMDT or SMDT. pg 88 IOG

• Workload for pathologists should conform to national guidance

• Receptor status:

Oestrogen receptor (ER) & HER2 status should be checked on all core biopsies that contain invasive disease.

Progesterone receptor (PR) should be tested if ER is negative

If hormone receptor status is negative or borderline on core biopsies consideration should be given to repeating that receptor status on the resection specimen.

Receptor status should be repeated on specimens from recurrences

### 3 Clinical Management of Patients Presenting with Early Breast Cancer

#### 3.1 General

• The Cancer Centre and the Cancer Units should agree clear local policies and guidelines for the management of patients with advanced or progressive disease. These policies should be designed to ensure the co-ordination of high quality care between Cancer Centres, Cancer Units, palliative care, primary care and community services.

• There should be rapid and efficient communication systems for liaison and cross-referral between all levels of service, including primary care, psychologists, cancer genetic specialists, social workers and palliative care.

• All newly diagnosed patients and all confirmed recurrences should be discussed at MDT

• There is no reliable research to define minimum acceptable workloads. The number of patients per annum should be sufficient to allow the team to function efficiently and to allow sensible analysis and interpretation of data.

#### 3.2 The Multi-Disciplinary Team (MDT)

This team is the forum for recommending treatment regimens for individual patients. These guidelines form the basis for discussion but do not preclude other treatments if deemed appropriate in individual cases.

• The team should meet at least weekly and there must be representatives from each of the groups by a core member or their arranged cover. For medical staff this should be the minimum of a career grade specialist. Attendance will be recorded and core members should attend two thirds of the meetings.

• The attendance at each individual, scheduled, treatment planning meeting, should constitute a quorum for 95% or more of the meetings.
• All core members of the MDT should attend at least two thirds of the number of meetings.
• The MDT has a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting.
• There will be a single named lead clinician for the MDT, who is a core team member. This position will be agreed by the lead clinician of the host trust, with agreed responsibilities for the role.
• The MDT operational policy should include a policy for identifying a single named key worker for the patients’ care for each individual patient. The name and contact number of the current key worker is recorded in the patient’s case notes. The responsibility for ensuring that the key worker is identified should be that of the nurse MDT member(s).
• The MDT should have at least one core nurse member who has successfully completed a programme of study in their specialist area of nursing practice, which has been accredited for at least 20 credits at first degree level or equivalent. The core nurse member has a list of responsibilities agreed with the MDT.
• The MDT should have a mechanism whereby after a patient is given a diagnosis of cancer, the patient’s general practitioner is informed of the diagnosis within 24 hours. This process should be audited.
• The MDT should have a mechanism for rapid referral between local and specialty MDTs and between MDTs for different tumour sites.
• A representative of the MDT must attend at least two thirds of CEG meetings.
• There must be at least an annual MDT meeting to discuss operational policies.
• The MDT offer patients the opportunity of a permanent record or summary of at least a consultation between the patient and the doctor.
• The MDT should have undertaken or be undertaking an exercise to obtain feedback on patients’ experience of the services offered.
• The core MDT agrees and records individual patient’s treatment plans. A record is made of the treatment plan.
• At least those core members of the team who have direct clinical contact with patients should have attended the national advanced communications skills training.

In addition the MDT must contribute to the following:

• Comparative report on services for patients presenting via breast screening and those symptomatic patients. This should look to detect inconsistencies in services, including assessment, clinical management and quality assurance arrangements.
• An action plan will be produced arising from the report and should assist in reducing the inconsistencies between the services, without detriment to either service individually and should address each of the issues outlined in the previous point, if relevant;
• The action plan will be agreed and signed off for approval by the CE of the trust(s) whose services will be affected by any proposed changes; at least one CE of the PCTs in the network as a representative of the commissioners and the lead clinicians of the breast MDTs in the network.
3.3 Core Members of the MDT

- 2 Designated breast surgeon(s)
- Nurse Practitioner (Where Applicable)
- 2 Breast care nurse specialists
- 2 Radiologists / Consultant Practitioners
- 2 Histopathologists
- 2 Oncologist – 1 Clinical and 1 Medical
- MDT Co-ordinator
- Member nominated responsible for recruitment to trials
- Core or extended member nominated responsible for patient / carer issues

3.4 Extended Members of the MDT

- A core member of the specialist palliative care team;
- Breast radiographer;
- Psychiatrist or clinical psychologist;
- Plastic/reconstructive surgeon;
- Clinical geneticist/genetics counsellor;
- Physiotherapist / lymphoedema.

Notes: The MDT may choose to name additional extended team members. Although there is not a requirement to have a named social worker as part of the extended team, there should be arrangements in place to access a social worker when required.

3.5 Multidisciplinary Team Meetings - See also Appendix (i)

North Bank MDT: Specialist & Local Multidisciplinary Team

YHFT & Scarborough Separate diagnostic and treatment MDTs, held on the same day, joint with York MDT

South Bank MDT: Local Multidisciplinary Team

Scunthorpe General Hospital / Diana Princess of Wales, Grimsby NLGFHT:

3.6 Surgical Management

The indications for local excision or mastectomy are usually relative and are discussed. There may be instances when mastectomy is the only option e.g. in multicentric disease over more than one quadrant. If patients prefer to undergo mastectomy it is essential that the surgeon records that all aspects of management, including reconstruction, have been discussed with and understood by the patient and if possible the patient’s reason recorded in the notes.

Oncoplastic procedures should be considered but must comply with criteria for adequate cancer treatment

Breast reconstruction should be available and may be appropriate at the time of the initial surgical operation. This should be discussed with the patient (see Breast Reconstruction guidelines)

In operable cases routine screening tests for metastatic cancer are not generally indicated.

Clips should be placed at the tumor bed as per the IMPORT Trial protocol which is listed below
Summary
- The medial, lateral, superior, inferior and deep cavity edges should be marked with titanium clips at the time of surgery.
- The deep clip should be positioned in the centre of the cavity. The peripheral clips should be positioned half way between skin and pectoral fascia.
- Clips should be placed in pairs to ensure that any clip migration will be evident by the visualisation of single clips.
- Clips should be used for ALL patients, even those where a tumour bed boost is not expected to be used.
- If breast re-modelling (to close the surgical defect) is performed then the clips should be placed as above before re-modelling.

Methodology
The following protocol describes a simple method of tumour bed localisation using titanium, surgical clips. Following wide local excision of the primary tumour down to pectoral fascia, 6 pairs of titanium, surgical clips will be inserted around the tumour bed. Each pair of clips will be positioned at the following six sites:

1. RADIAL
At four points of the radial margin (medial, lateral, superior and inferior, half way between the skin and pectoral fascia).

![Figure 1. Anterior and lateral view of breast showing surgical cavity (star) and pairs of clips.](image)

2. DEEP
At the midpoint of the deep margin, usually, but not necessarily, the pectoral fascia (posterior)

3. ANTERIOR
In the subcutaneous tissue, close to the suture line, avoiding skin dimpling (anterior).

If a specimen X-ray is taken, the image must be reported by the surgeon or by the radiologist. PACS image access must be available to the pathologist and to the MDT.

Patients are referred on for adjuvant treatment that is dependent on the surgery done, the pathological characteristics of the tumour and the axillary status. This should always be discussed at the MDT meeting and appointments for discussion of the outcome with the oncologist should be within two weeks following the decision to proceed. If there is any delay in MDT discussion, management may go ahead providing it is confirmed retrospectively at the MDT meeting.
3.7 Axillary staging

All confirmed invasive malignant cases should have axillary node staging either by sentinel node biopsy or clearance, as appropriate.

Sentinel lymph node biopsy (SLNB) is the preferred technique for staging of the axilla in patients with early invasive breast cancer and no evidence of lymph node involvement on ultrasound or a negative ultrasound-guided needle biopsy. SLNB should only be performed by a team that is validated in the use of the technique, as identified in the NEW START training programme. SLNB should be performed using the dual technique with isotope and blue dye.

3.8 Staging Investigations in Early Breast Cancer

Routine staging investigations are not recommended in early breast cancer and have not been associated with improving long term outcomes (RCR 2006, ASCO 2006). Routine staging in unselected patients picks up <5% distant metastases (Muller et al 2008, Kim et al 2011).

Based on local audits staging in the form of an initial CT Chest / Abdomen / Pelvis should be considered for the following groups of patients:

- Inflammatory/ locally advanced breast cancers
- Post-surgical patients with pN3 disease (10 or more nodes involved)
- Post-surgical patients with pN2 disease with >50% ratio of involved nodes
- Symptomatic patients with a clinical suspicion of metastatic disease

Bone scan should be added in patients with confirmed bone metastases on CT to ascertain the extent and sites of bone metastases.

3.9 Treatment of positive axillary nodes:

Patients found to have macro metastases in sentinel nodes may be offered a choice between radiotherapy to the axilla or surgical clearance.

- Patients who have obvious heavy axillary involvement at preoperative assessment, or who are found to have all four nodes involved on sampling, should have a formal axillary clearance to treat the axilla rather than rely on radiotherapy which may not be so effective in the presence of extensive axillary involvement.

- Patients with axillary micro metastases should be considered for further axillary therapy depending on other tumour and patient characteristics. Patients with isolated tumour cells in sentinel nodes should be considered node negative.

- Regular review is required as application of these options.

3.10 Excision margins for Breast Conserving Surgery

Patients with DCIS

- A minimum of 2mm radial margin of excision is recommended, with pathological examination to NHSBSP reporting standards.

- Consider re-excision if margin < 2mm after discussion of risks and benefits with patient.

Patients with invasive disease

- No cancer cells at any margin – clear
- Cancer cells at any margin – involved
- Cancer cells less than 1mm from any margin – close, re-excision should be considered.
3.11 Treatment of Patients with Paget's Disease of the Nipple

Disease assessed as localised
- Offer breast conserving surgery with removal of the nipple–areolar complex as an alternative to mastectomy.
- Offer oncoplastic repair techniques to maximise cosmesis.

3.12 Adjuvant Radiotherapy

It is now known that postoperative radiotherapy improves both local relapse free and overall survival.

3.13 After Wide Local Excision

Ductal Carcinoma In-Situ (DCIS)

Radiotherapy for low risk DCIS remains controversial. There is evidence from randomised trials that post-operative radiotherapy following wide local excision reduces local recurrences of DCIS/invasive breast cancer (Fisher et al JCO 1998, Bijker JCO 2006). However, the natural history of the disease can be long and local recurrences occur several years from original surgery. There is no survival benefit from radiotherapy treatment in DCIS.

There are no clear consensus guidelines for breast radiotherapy for DCIS. The Van Nuys Prognostic Index is a retrospective analysis (Silverstein et al Cancer 1996) but may aid decision making alongside patient factors such as age/life expectancy.

<table>
<thead>
<tr>
<th>Van Nuys Prognostic Index</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Size (mm)</strong></td>
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<tr>
<td>&lt;15</td>
</tr>
<tr>
<td>&gt;10</td>
</tr>
<tr>
<td><strong>Margin (mm)</strong></td>
</tr>
<tr>
<td><strong>Pathology</strong></td>
</tr>
<tr>
<td>Low/int grade</td>
</tr>
<tr>
<td>no necrosis</td>
</tr>
<tr>
<td><strong>Score</strong></td>
</tr>
<tr>
<td>3-4</td>
</tr>
<tr>
<td>5-7</td>
</tr>
<tr>
<td>8-9</td>
</tr>
</tbody>
</table>

Invasive Breast Cancer

Indications:
- All patients who have breast conserving surgery

Boost for Tumour Bed

Indications:
- Patients 40 years of age or under with invasive disease
- Patients over 50 years with grade 3 tumours
- Patients over 50 years with radial margins less than 2mm

Volume: Tumour bed and a margin of 1 cm all around. Tumour bed is identified with information from surgical clips, notes, scar, preoperative imaging and by palpation for missing tissue.

Dose: 10Gy in 5 fractions
Energy: As clinically appropriate
Post Mastectomy Radiotherapy

Absolute indications:
- Tumour >50 mms.
- Involvement of 4 or more axillary nodes
- Involvement of deep surgical margins

Relative indications:
If two of the following risk factors present consider chest wall radiotherapy
- Patients with 1-3 nodes positive
- Lympho-vascular invasion
- Grade 3
- Age 35 or under


3.14 Radiotherapy to Axillary & Supraclavicular Nodes

- Lymph node negative or isolated tumour cells on SNLB: no radiotherapy
- Axillary micrometastases on SNLB: consider axillary radiotherapy depending on other prognostic and predictive factors
- Macrometastases on SNLB or 4 node axillary sample: offer radiotherapy to the axilla and SCF if not having axillary clearance
- 4 or more positive nodes: offer radiotherapy to SCF
- 1-3 positive nodes and other poor prognostic factors: offer radiotherapy to SCF
- Do not offer radiotherapy to internal mammary chain

3.15 Adjuvant Chemotherapy

Adjuvant therapy planning

All patients with early invasive breast cancer:

- After surgery, consider adjuvant therapy at the MDT meeting. Record all decisions.
- Make decisions about adjuvant therapy based on assessment of prognostic and predictive factors and potential benefits and side effects of the treatment. Make decisions following discussion of these factors with the patient.
- Consider using Adjuvant! Online (www.adjuvantonline.com) to support estimations of individual prognosis and absolute benefit of adjuvant treatment.
**Adjuvant Chemotherapy**

Adjuvant chemotherapy should be based on assessment of risk. This should take into account the adjusted NPI score, ER and HER2 status, menopausal status, co-morbidity and patient preferences.

<table>
<thead>
<tr>
<th>Adjusted NPI</th>
<th>Pre-menopausal</th>
<th>Post-menopausal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score</td>
<td>ER -ve</td>
<td>ER +ve</td>
</tr>
<tr>
<td>&lt;2.4</td>
<td>Nil</td>
<td>Tamoxifen</td>
</tr>
<tr>
<td>2.41-3.4</td>
<td>? EC</td>
<td>Tamoxifen</td>
</tr>
<tr>
<td>3.41-4.4</td>
<td>EC</td>
<td>EC Tamoxifen</td>
</tr>
<tr>
<td>4.41-5.4</td>
<td>FEC-T</td>
<td>EC or FEC-T Tamoxifen</td>
</tr>
<tr>
<td>&gt;5.4</td>
<td>FEC-T</td>
<td>FEC-T Tamoxifen</td>
</tr>
</tbody>
</table>

Proposed stratification of risk for patients being considered for systemic treatment using NPI.

NPI Score = Grade (1-3) + lymph node status + tumour size (cm x 0.2)

Lymph node stage score:  
- all negative: 1  
- 1-3 positive: 2  
- 4 or more positive: 3

Sentinel node score:  
- Negative: 1  
- Positive: 3

Adjuvant online should be utilised in groups where benefits of chemotherapy are less clear to supplement decision making. The HER2 + group obviously have a higher inherent risk of relapse and death which cannot currently be explored using adjuvant online. St Gallen guidelines would suggest they should be in an intermediate risk group at least. A pragmatic approach would be to use

Adjusted NPI Score = NPI Score + 1 (if HER2+ or age < 35 years)

Anthracycline based chemotherapy should remain the standard of care. However, based on the stratification of risk, using adjusted NPI (see table) subgroups of patients should be considered for taxane based chemotherapy. Patient characteristics, for example biological age, co morbidity, patient preference and toxities of treatment should be taken into consideration.

In HER2+ patients’ trastuzumab should be started as soon as anthracycline chemotherapy has been completed.

Patients unsuitable for anthracycline based chemotherapy should be considered for docetaxel plus cyclophosphamide (when HER2-ve) or docetaxel plus carboplatin plus trastuzumab (when HER2+ve).

**3.16 Ovarian Functions and Fertility Issues**

Issues surrounding ovarian function and fertility should be discussed with all female patients of child bearing age prior to starting adjuvant therapy.

These issues are complex and patients should be referred to the Hull IVF centre Secretary: Linda Browne HRI 602757)
3.17 Trastuzumab (Herceptin®)

All women with newly diagnosed breast cancer will be tested for HER 2 status.

Figure 1: HER 2 testing in Breast cancer

Eligibility for trastuzumab (Herceptin) – for Early Breast Cancer

As outlined by guidance from the national institute for health and clinical effectiveness. All women who have HER-2 positive early breast cancer and have had adjuvant chemotherapy are eligible for:

- Trastuzumab, given at 3-week intervals for 1 year or until disease recurrence (whichever is the shorter period), is recommended as a treatment option for women with early-stage HER2-positive breast cancer following surgery, chemotherapy (neoadjuvant or adjuvant) and radiotherapy (if applicable).
- Cardiac function should be assessed prior to the commencement of therapy and trastuzumab treatment should not be offered to women who have a left ventricular ejection fraction (LVEF) of 40%* or less, or who have any of the following:
  - A history of documented congestive heart failure
  - High-risk uncontrolled arrhythmias
  - Angina pectoris requiring medication
  - Clinically significant valvular disease
  - Evidence of transmural infarction on electrocardiograph (ECG)
  - Poorly controlled hypertension.
- Cardiac functional assessments should be repeated every 3 months during trastuzumab treatment.

*This represents the lower limits of normal LVEF based on MUGA scanning in the NEYHCA region.
Dosing for trastuzumab for early breast cancer should follow the schedule listed in the HERA study:

Either:
- 8mg/kg loading dose and 6mg/kg maintenance dose given at three weekly intervals
- 4mg/kg loading dose and 2mg/kg maintenance dose via a weekly infusion

The current recommended duration of treatment with trastuzumab is 12 months.

### 3.18 Adjuvant Endocrine Therapy

It is clear that women with oestrogen receptor positive tumours benefit from up to 10 years of antioestrogen therapy. Patients with hormone receptor negative disease should not receive endocrine therapy. If the patient is receiving adjuvant chemotherapy endocrine therapy should be deferred until chemotherapy has finished.

Patients with DCIS should not be offered tamoxifen. They should be entered into the appropriate clinical trial.

### 3.19 Aromatase Inhibitors

- All (Aromatase Inhibitors) AIs increase the risk of osteoporosis and its complications. Therefore, all patients who receive an aromatase inhibitor should be advised regarding the implications for osteoporosis.
- All patients commencing an AI should have a dexta scan.

Bone density should not prevent the prescription of aromatase inhibitors. However, all women who have finished chemotherapy and have commenced treatment with an aromatase inhibitor should have further dexta scans according to the results of the baseline scan and recommendations from the bone metabolic unit.

Lifestyle advice should be given to help reduce the risk of osteoporosis such as regular weight bearing exercise, cessation of smoking and a high calcium diet.

Discuss with women the risks and benefits of each treatment option. Consider previous treatment with tamoxifen, licensed indications and side-effect profiles of individual drugs and, in particular, assessed risk of recurrence.

### 3.20 Pre-menopausal Patients

There is good evidence that adjuvant tamoxifen reduces risks of recurrence in pre-menopausal women. Therefore, all pre-menopausal women except those with T1G1N0 should receive 5 years of tamoxifen 20 mg once a day.

Pre-menopausal patients who decline chemotherapy should be offered ovarian ablation and tamoxifen.

Pre-menopausal patients where tamoxifen is contra indicated should be offered ovarian ablation.

Any abnormal vaginal bleed whilst on Tamoxifen® should be appropriately investigated.

### 3.21 Extended Adjuvant therapy

High risk patients who have received 5 years of tamoxifen and have become post-menopausal should be considered for extended use of letrozole 2.5 mg once a day for 5 years.

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References


4. Neo Adjuvant Therapy

Chemotherapy

Neo adjuvant chemotherapy has been shown to be as efficacious as adjuvant treatment with the added benefit it may result in down staging which may allow more conservative local therapy *.*

Patients should be considered for neo adjuvant chemotherapy

- Down staging the tumour might allow breast conservation, which would be otherwise impossible
- Inoperable breast cancer
- Inflammatory breast cancer

Patients should be discussed at the MDT. All patients to be staged with CT.

It has also been shown that the sequential addition of docetaxel to anthracycline regimens improves the outcome ***

Therefore the standard regimen will be FEC100 x 3 followed by docetaxel x 3. If patients considered unfit for taxanes then anthracylines alone may be sufficient. HER2 positive patients should start herceptin concurrently with docetaxel.

All 6 cycles to be given before surgery

- All patients should have an MRI scan before treatment
- All patients should have clinical examination and tumour measurements performed before each cycle.
- All patients in whom the aim of treatment is to enable breast conserving surgery should have a marker placed in the tumour under US guidance, before treatment where possible.
- If no US marker is placed at the beginning of treatment then the patient will need to be monitored clinically and a marker requested if the tumour is responding and measures less than 3cm.
- All patients aiming for breast conserving surgery should have an MRI at the end of chemotherapy.
Staging the Axilla in Neo Adjuvant Chemotherapy

- Patients who are node negative on axillary US before chemotherapy should have a SNB after chemotherapy. If the SNB is negative these patients are to be treated as node negative patients.
- Patients who have a positive FNAC or core of axillary node before chemotherapy should be discussed at MDT after chemotherapy and axillary staging and treatment planning should be based on the measured response to chemotherapy.
- Patient and tumour characteristics should be taken into consideration.
- Patients with inflammatory breast cancer should have a formal mastectomy and axillary clearance after chemotherapy. Skin sparing mastectomy is not appropriate in these patients.

References


Radiotherapy after Neo Adjuvant Chemotherapy

- All patients having BCS should have adjuvant radiotherapy as per guidelines for early breast cancer.
- Patients who are T3 before chemotherapy should have post mastectomy chest wall radiotherapy irrespective of response to chemotherapy.
- All patients with inflammatory breast cancer should receive post mastectomy radiotherapy to the chest wall with bolus and SCF.

Neo Adjuvant Endocrine Therapy

Neo Adjuvant therapy with aromatase inhibitors can be offered to post-menopausal patients with strongly ER and PR positive disease. In order to enable BCS, which would otherwise be impossible or unwise. A tumour bed marker should be inserted at the start of therapy. The optimum duration of treatment depends on response. Patients should be monitored clinically and with US when clinically indicated. Surgery should be considered as soon as the tumour is small enough to allow breast conserving surgery.

Patients with lobular breast cancer should have an MRI before starting treatment.

Patients with grade 3 disease or node positive at presentation should be considered for neo adjuvant chemotherapy not endocrine therapy.
5. Treatment of Advanced / Metastatic Disease

5.1 Radical Radiotherapy Alone (Without Surgery)

Radiotherapy as a main local treatment may be considered in the following conditions:

- Inoperable tumour
- Patient medically unfit for surgery
- Patient unwilling for surgery

5.2 Palliative Radiotherapy

5.21 Brain Metastasis

- Offer surgery followed by whole brain radiotherapy to patients who have a single or small number of potentially resectable brain metastases, a good performance status and who have no or well-controlled other metastatic disease.
- Offer whole brain radiotherapy to patients for whom surgery is not appropriate, unless they have a very poor prognosis.
- Offer active rehabilitation to patients who have surgery and/or whole brain radiotherapy.
- Offer referral to specialist palliative care if active treatment for brain metastases would be inappropriate.

High dose dexamethasone should be given as first line therapy at an initial dose 16 mg/day with a proton pump inhibitor. Anti convulsants should be used if there is history of convulsions

Surgery should be considered only for patients with good performance status, long disease free survival, solitary metastasis and no extra cranial disease

Whole brain radiotherapy may improve symptoms in patients with good performance status (PS) and more favourable prognosis.

5.22 Whole Brain Radiotherapy: (See protocols in RT dept)

Dose: 20Gy in 5 fractions or 30Gy in 10 fractions  
Energy: 6 MV photons

5.23 Spinal Cord Compression (See protocols in RT dept)

Patients with good performance status and short history of leg weakness who are not considered suitable for surgery should receive urgent palliative radiotherapy preferably within 24 hours of the confirmation of the diagnosis. MRI should be done to localise the site(s) of compression.

Dose: 20Gy in 5 fractions or 30Gy in 10 fractions  
Energy: 6 MV photons

5.24 Nodal or Skin Metastasis (See protocols in RT dept)

Technique, energy, and position vary according to site and size of the disease. Bolus the skin if it is involved. Consider electrons, especially over skull

Dose: 20 Gy in 5 fractions over 1 week or 10 Gy in single fraction

5.25 Bone Metastasis

Indications for radiotherapy include:

- Pain
- Nerve root compression
- Spinal cord compression
- Pathological fracture
5.3 Treatment options

- An orthopaedic surgeon should assess patients at risk of a long bone fracture, to consider prophylactic surgery.
- Adequate analgesia including non-steroidal, opiates, steroids, co analgesics, nerve block
- Non drug modalities e.g. TENS
- Bisphosphonate therapy
- Surgery should be considered in the presence of cord compression, pathological fracture or imminent fracture

Dose: 8Gy single fraction or 20Gy in 5 fractions

5.4 Endocrine treatment in Metastatic Breast Cancer

To be used in
- ER / PR positive tumours
- Can be used as primary treatment in slowly progressive disease, no visceral involvement and minimal symptoms.

Post-menopausal women* (assuming no adjuvant endocrine treatment):
1st line: Aromatase inhibitors (letrozole / anastrozole)
2nd line: Switch to steroidal aromatase inhibitors (exemestane)
3rd line: Fulvestrant or tamoxifen

Prior adjuvant endocrine treatment should be taken into consideration

Pre-menopausal women:
Received adjuvant tamoxifen with relapse free interval <1 year*:
1st line: Ovarian ablation
2nd line: Ovarian ablation plus aromatase inhibitors
3rd line: Continue ovarian ablation plus switch to steroidal aromatase inhibitors (exemestane) or fulvestrant

Not received adjuvant tamoxifen or received adjuvant tamoxifen with relapse free interval >1 year*:
1st line: Consider restarting tamoxifen
      or
2nd line: Ovarian ablation plus aromatase inhibitor
3rd line: Ovarian ablation plus switch to steroidal AI (exemestane) or fulvestrant

*Chemotherapy may be considered at any stage depending on site of disease and patient characteristics

5.5 Chemotherapy in metastatic disease

If the patient presents with metastases or is placed in stage 4 after assessment, surgery is not part of the treatment unless to palliate some particular symptom or clinically appropriate.

Investigations are done as appropriate to enable planning of systemic treatment. Patients with hormone receptor status positive with non-life threatening or severe symptoms should be treated with an endocrine agent as determined by their menopausal status. Post-menopausal women should be treated with an aromatase inhibitor in preference to tamoxifen.”
For patients with advanced breast cancer who are not suitable for anthracyclines (because they are contraindicated or because of prior anthracycline treatment either in the adjuvant or metastatic setting), systemic chemotherapy should be offered.

See Metastatic Treatment Algorithm Appendix (v)

Patients with advanced triple negative disease can be considered for platinum based chemotherapy after discussion from the Breast Oncology Group meeting.**

### 5.6 Bisphosphonates

All patients with significant bone metastases should be treated with bisphosphonates or Denosumab to reduce skeletal related events. Those patients who require IV bisphosphonate with chemotherapy should be prescribed Zometa (zoledronic acid) 4mg every 21 - 28 days with calichew D₃ Forte or Calceos. Otherwise oral Ibandronate 50mg daily should be used. IV Ibandronate should be used where creatinine clearance is less than 40mls/min.

For Treatment Algorithm see Appendix (v)

### 5.7 Radiotherapy for Ductal Carcinoma In Situ (DCIS)

Radiotherapy for low risk DCIS remains controversial. There is evidence from randomised trials that post-operative radiotherapy following wide local excision reduces local recurrences of DCIS/invasive breast cancer (Fisher et al JCO 1998, Bijker JCO 2006). However, the natural history of the disease can be long and local recurrences occur several years from original surgery. There is no survival benefit from radiotherapy treatment in DCIS.

There are no clear consensus guidelines for breast radiotherapy for DCIS. The Van Nuys Prognostic Index is a retrospective analysis (Silverstein et al Cancer 1996) but may aid decision making alongside patient factors such as age/life expectancy.

<table>
<thead>
<tr>
<th>Van Nuys Prognostic Index</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Size</strong> (mm)</td>
</tr>
<tr>
<td>&lt;15</td>
</tr>
<tr>
<td>16-40</td>
</tr>
<tr>
<td>&gt;41</td>
</tr>
<tr>
<td><strong>Margin</strong> (mm)</td>
</tr>
<tr>
<td>&gt;10</td>
</tr>
<tr>
<td>1-9</td>
</tr>
<tr>
<td>&lt;1</td>
</tr>
<tr>
<td><strong>Pathology</strong></td>
</tr>
<tr>
<td>Low/int grade</td>
</tr>
<tr>
<td>Low/int grade</td>
</tr>
<tr>
<td>High grade</td>
</tr>
<tr>
<td>no necrosis</td>
</tr>
<tr>
<td>necrosis</td>
</tr>
<tr>
<td>necrosis</td>
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<tr>
<td><strong>Score</strong></td>
</tr>
<tr>
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<tr>
<td>No radiotherapy</td>
</tr>
<tr>
<td>5-7</td>
</tr>
<tr>
<td>Intermediate</td>
</tr>
<tr>
<td>Recommend radiotherapy</td>
</tr>
<tr>
<td>8-9</td>
</tr>
<tr>
<td>High risk</td>
</tr>
<tr>
<td>Consider mastectomy</td>
</tr>
</tbody>
</table>

### 5.8 Tumour Bed Boost Treatment Following External Beam Radiotherapy to Intact Breast

The main evidence base for breast boost radiotherapy relates to the EORTC boost trial (Bartelink NEJM 2001, JCO 2007). This comprised of 5318 patients with microscopically completely excised early breast cancers. The median age was 55 years with no patients over 70 years included in the trial. Patients were randomised to 50Gy/25# to the breast ± 16Gy/8# boost to the tumour bed.

The greatest effect in this study was for patients < 40 yrs (LR 23.9% vs 13.5% at 10 years). For patients greater than 50 years LR was < 8% at 10 years without a boost. For patients 41-50 yrs LR was reduced from 12.5% to 8.7%.
There is no improvement in overall survival at 10 years with breast boost treatments. There are also problems related to cosmetic outcomes (severe fibrosis increased from 1.6% to 4.4% and moderate fibrosis 13.2% vs 28.1%). You would need to treat 33 patients with a boost if over 50 to prevent 1 LR with no impact on OS.

A pathological review following this study (Jones et al JCO 2009) suggests only age <50 and Grade of tumour are significantly associated with local recurrence on multivariate analysis. Absence of systemic treatment was almost significant.

The above trials have to be put in context in that they recruited over 20 years ago and systemic treatments for breast cancer have improved significantly resulting in lower local recurrences.

Optimal planning of tumour bed boost treatments requires utilisation of surgical clips to mark the tumour bed. The accepted best practice is to use pairs of clips to mark the boundaries of the tumour bed.

The recommendations for breast boost treatments are:

1. All patients < 40 years of age
2. All patients 41-50 years with either G3 tumours or circumferential margin ≤ 2mm.

References


6. Complications of Local Treatment and Menopausal Symptoms

<table>
<thead>
<tr>
<th>Complication</th>
<th>Information and advice</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Lymphoedema          | • Inform patients about the risk and give them written information before offering surgery and radiotherapy.  
• Give advice on how to prevent infection or trauma. | • Ensure rapid access to a specialist lymphoedema service.                                    |
| Arm mobility         | • Give instructions on functional exercises, which should start the day after surgery, to patients having axillary surgery. This should include relevant written information from a member of the breast or physiotherapy team.  
• Identify pre-existing shoulder conditions preoperatively.  
• Refer patients to the physiotherapy department if they report a persistent reduction in arm and shoulder mobility after breast cancer treatment.  
• Breast units should have written local guidelines agreed with the physiotherapy department for postoperative physiotherapy regimens. |                                                                                              |
| Menopausal symptoms  | • Offer information and counselling about the possibility of early menopause and menopausal symptoms associated with breast cancer treatment.  
• Discontinue HRT in women diagnosed with early breast cancer.  
• Do not offer HRT (including oestrogen/progesterone combination) routinely to women with menopausal symptoms and a history of breast cancer.  
• HRT may, in exceptional cases, be given to women with early breast cancer who have severe menopausal symptoms, as long as the woman has been fully informed about the associated risks.  
• SSRI antidepressants (paroxetine and fluoxetine) may be used to relieve menopausal symptoms, particularly hot flushes, but not in women taking tamoxifen.  
• Clonidine, venlafaxine and gabapentin should only be used to treat hot flushes after the woman has been fully informed of the significant side effects.  
• Tibolone, progesterogens, oestrogen, red clover, black cohosh, vitamin E and magnetic devices are not recommended to treat menopausal symptoms. |                                                                                              |

6.1 Managing Complications

**Lymphoedema**
- Identify any treatable underlying factors before starting lymphoedema therapy.
- Offer complex decongestive therapy (CDT) as the first form of management.
- Consider multi-layer lymphoedema bandaging (MLLB) for volume reduction before compression hosiery.
- Provide patients with at least two compression garments. They should be the correct class and size, and a choice of fabrics and colours should be available.
- Provide information about lymphoedema and contact details of local and national lymphoedema support groups.

**Cancer-related fatigue**
- If cancer-related fatigue is a significant problem, offer an assessment to identify any treatable causative factors and offer appropriate management.
- Provide information about cancer-related fatigue, organisations that offer psychosocial support and patient-led groups.
- Provide information about and timely access to an exercise programme.

**Uncontrolled local disease**
• A breast cancer multidisciplinary team should assess patients and discuss the therapeutic options for controlling the disease and relieving symptoms.
• A wound care team should see patients with fungating tumours to plan a dressing regimen and supervise management with the breast care team.
• A palliative care team should assess patients to plan a symptom management strategy and provide psychological support.

6.2 Menopausal Symptoms

See table above

Acupuncture also has a proven benefit for menopausal flushes

6.3 Musculo-skeletal Symptoms arising from AIs

Advise non steriodal analgesia and consider switching to alternative endocrine therapy.

6.4 Abnormal PV Bleeding on tamoxifen

Should be investigated by a gynaecologist

7. Children, Teenagers & Young Adults

7.1 IOG Key Principles

Who does this apply to?
• All patients aged 16-24 with cancer
• (2 age groups 16-18 years and 19-24 years)

What needs to happen?
• All patients aged 16-18 years inclusive should be referred to a Principal Treatment Centre (Young People) for treatment
• All patients aged 19-24 years inclusive should be offered referral to a Principal Treatment Centre (Young People) for treatment.
• All patients aged 16-24 years inclusive should be discussed at both a site-specific MDT meeting and a TYA MDT meeting.
• Referral of patients to a PTC (Young People), or review by both a site-specific and a TYA MDT should not be allowed to delay the start of urgent cancer treatment.
• For each patient, a lead medical clinician should to be identified, who will have overall responsibility for their treatment.

Ref: Children &Young People’s Improving Outcomes Guidance - Implementation - August 2008

Why?
• The 2005 NICE IOG on Children and Young People mandates this model of decision-making and care (key principles)
• These young people have particular needs in terms of communication, supportive care and environment of care, that are best served by referral
• The particular spectrum of diseases between MDTs
• This is what young people want to happen, when asked
When does referral need to happen?
- As soon as you are aware of (or have a high suspicion of) a diagnosis of cancer & in time for the TYA team to be involved in decisions about pattern and place of care i.e. before the management plan is negotiated with the patient.

How is this referral made?
- Referral to be made using process agreed in the Standard Operating Procedure (Set up in conjunction with the Yorkshire Cancer Network)

7.2 Standard Operating Procedure

To view a copy of the Standard Operating Procedure please check the NEYHCA (Cancer) website. Please press control and click on the following link

http://www.hyccn.nhs.uk/NetworkGuidelinesAndPublications/CYA.htm
7.3 Pathway for Teenagers & Young Adults with Cancer V1.3 (YCN & NEYHCA Cancer)
8. Follow Up of Patients with Breast Cancer

This section provides all trust staff with information about their responsibilities in adhering to the guideline.

The section applies to
- Macmillan Breast Care Nurse Specialist Team.
- Breast multidisciplinary Team.

Responsibilities
- The breast multidisciplinary team practice the guideline.
- All health professionals to adhere to the guideline when referring to the Breast Care Follow up Programme

Increasing numbers of women and men are surviving breast cancer, and living with the long term effects of diagnosis and treatment. Nationally, 5 year survival rates for breast cancer are greater than 80% and the 10 year predicted survival rate is now 77%. (Cancer Research UK, 2009).

Cancer survivors face many issues, including physical, psychological, financial and social, any of which might be ongoing for the rest of their lives (DoH 2007, DoH, NHS Improvement, Macmillan Cancer Support 2010). There is good evidence that routine “follow up” is costly and fails to address patient’s needs, does not improve detection of recurrent or new disease and there is no evidence that any one particular model offers advantages over any other (DoH 2011).

It is known that patients have increased needs at around one year after their diagnosis, during the transition from active treatment to follow up. (Vivar C, McQueen A, 2005). There is now growing evidence that post treatment support programmes can increase quality of life and psychological functioning and reduce disability from cancer (DoH 2010).

Current guidance from NICE (2002) advises annual mammographic follow up for 5 years or until screening age, but does not specify either the frequency or duration of clinical follow up. Increasingly traditional clinical follow up is being replaced with a programme based on the Macmillan National Cancer Survivorship Initiative. This model uses an aftercare framework which is supportive, responsive and tailored to individual patient needs. Patients will continue to have mammographic surveillance as per the NICE guidelines.

Indications for following a patient vary from case to case depending on the treatment received and any other oncological factors.

Using the Survivorship Program model the standard follow up is 5 years. The details of model are listed below: All patients will receive a personalised follow up plan. The personalised plan may be altered from the standard (as detailed below) by individual clinical circumstances and also by protocol for any clinical trial in which they may be participating.

Clinical follow-up
- After adjuvant treatment (including chemotherapy and/or radiotherapy, where indicated) is completed, discuss with patients where they would like follow-up to be undertaken. They may choose primary, secondary or shared care.

Patients treated for breast cancer should have an agreed, written care plan, which should be recorded by a named healthcare professional (or professionals), a copy sent to the GP and a personal copy given to the patient. This plan should include:

- Designated named healthcare professionals
- Dates for review of any adjuvant therapy
• Details of surveillance mammography
• Signs and symptoms to look for and seek advice on
• Contact details for immediate referral to specialist care, and
• Contact details for support services, for example support for patients with lymphoedema.

Any follow-up plan must state the mechanism by which patients can be referred back to clinics at other times. This will usually be through a breast care nurse as their key worker.

• During the first year, patients are seen as necessary for their adjuvant treatment.
• Patients well-being should be taken into consideration when deciding follow up.
• Patients currently being followed up may contact the Key Worker or the Breast Clinic direct to bring forward an appointment for any new concern.
• On discharge patients should be given an information leaflet.
• All Patients should be reviewed on completion of adjuvant treatment.
• All patients should be reviewed 12 months post-surgery with mammographic follow up, even if still on adjuvant Herceptin.
• Patients should have yearly mammograms for at least five years or until 50 years of age
• From age 50 patients should be encouraged to attend for routine mammograms through the screening programme.

The details of the HEY Survivorship Program are listed in appendix (VI)

8.1 Other Follow up Investigations

Other investigations may be requested particularly in relation to research protocols, e.g. tumour markers.
• On suspicion of local recurrence or metastatic disease - imaging and biopsy as appropriate

8.2 Contact Points for Patients Following Discharge

If after discharge from routine follow up a patient develops a problem, referral back to the clinic can be made by referral from their GP.

8.3 Rehabilitation Pathway

In accordance with National Guidance the Network as agreed a breast specific rehabilitation pathway which can be accessed via the NEYHCA website
9. Breast Reconstruction

General principles

- All major types of reconstructive procedure should be available within the network. As a minimum this should include implant based reconstruction, latissimus dorsi myocutaneous flaps, pedicled and free TRAM flaps, DIEP flaps and SGAP flaps. It is imperative that microvascular surgical skills be maintained to enable provision of modern reconstructive options.

- All patients requiring or choosing mastectomy should have immediate breast reconstruction discussed with them by their breast surgeon. If they are unsuitable for an immediate reconstruction this should have been discussed at MDT and the patient should be given the reasons for this decision. Patients should be advised that delayed reconstruction remains an option.

- Immediate breast reconstructions should be prioritized to ensure timely surgery and adjuvant therapy and should be treated within the 31/62 day targets, irrespective of the type of reconstruction planned, as long as this is appropriate for the individual patient.

- Immediate breast reconstruction should be performed by a team of surgeons with the necessary knowledge and skills to perform both the cancer surgery and the reconstruction. This improves both patient safety and theatre utilization.

- Patients who are likely to need postmastectomy radiotherapy should be cautioned regarding purely implant based reconstruction. These patients may benefit from delayed-immediate reconstruction with a temporary submuscular tissue expander prior to completion of reconstruction after adjuvant therapy.

- Patients who may achieve a significantly improved aesthetic outcome from breast conserving surgery and radiotherapy by the use of reduction techniques for resection (therapeutic mammoplasty) should be referred urgently to a surgeon offering this procedure. The use of such techniques should not significantly delay resection surgery or adjuvant treatment.

- All patients who have had a mastectomy should have the option of delayed reconstruction offered at follow-up visits. It should be documented clearly that a patient has been offered reconstruction.

- Delayed breast reconstruction is an important part of breast cancer survivorship for many patients. It should be provided by the NHS without any limits on the length of delay or the provider of the initial mastectomy.

- Patients waiting for delayed reconstruction should be placed on waiting list pathway (e.g. 18 weeks) for elective surgery.

- Patients who have had chest wall radiotherapy should be advised to wait a minimum of 6 months before reconstructive surgery.

- Patients with a defect or asymmetry following breast conserving surgery should be offered surgical correction where appropriate.
• All patients should be discussed at either an oncoplastic MDT or in a shared clinic. Where this is not possible, referral pathways should be agreed between breast surgery and plastic surgery.

• All patients considering reconstruction should be seen in a specialist clinic where breast care nurse support is available.

• Patients should have access to information about the various types of reconstruction available and the associated risks and complications. This may be best achieved using a patient information video.

• Patients should be offered a choice of all reconstructive options appropriate for them and the patient’s wishes must be taken into account when deciding on surgery.

• In line with national guidelines, all component parts of the reconstructive pathway should be funded without exception by the NHS. This includes lipomodeling, nipple reconstruction and tattooing, -symmetry surgery, revision of reconstruction and secondary reconstruction.

• In order to accurately record cosmetic outcomes, preoperative and postoperative photographs should be taken and securely stored on the hospital system. These should include agreed standard views and should be taken by a professional medical photographer.

10. Lipomodelling for Patients Following Breast Conserving Surgery

The NEYHCA (Cancer) Breast Clinical Expert Group has reviewed the joint guidelines on lipomodelling from the Association of Breast Surgery, the British Association of Plastic, Reconstructive and Aesthetic Surgeons and the British Association of Aesthetic Plastic Surgeons. The draft guidelines can be accessed via the below weblink


The NEYHCA (Cancer) specific guidelines around lipomodelling are outlined below

Consent and Audit
All patients undergoing lipomodelling should be fully consented and provided with clear information regarding the lack of data available about recurrence.

Each department offering lipomodelling within NEYHCA should have a departmental database holding data regarding patients undergoing lipomodelling following breast conserving treatment for breast cancer. This data should be regularly audited.

Imaging
Patients should have had a clear mammogram less than 1 year prior to commencing lipomodelling treatment.

All patients having lipomodelling should have a mammogram within 1 year post completing lipomodelling.
11. Palliative Care Guidelines

Patients who will need a palliative care pathway are identified through the weekly Multidisciplinary Team (MDT). The reasons for curative treatment options not being appropriate are discussed and a management strategy is proposed.

Following discussions with patients and their families a plan of treatments and care will be organized. This may include singularly or in combination: surgery, radiotherapy or chemotherapy and symptom management, with referrals to specialist services including allied health professional services as appropriate. Referrals to community services would also be instigated as appropriate. Patients will continue to be reviewed by the clinical team as required. Referral to specialist palliative care can be facilitated through any team member, but is often undertaken by the CNS as they have developed links with the community palliative care nurses throughout the region and the hospices in Hull, Grimsby, Scunthorpe and Scarborough.

Specialist Palliative Care Teams can provide access to a range of services including

- Day care
- Admission for symptom relief
- Rehabilitation
- Terminal care
- Bereavement counselling
- Pain clinics / Pain Management
- Complementary therapies (e.g. reflexology, aromatherapy)
- Lymphoedema Management services
- Psychological support
- Help with benefits and social care issues.

(Plus, all patients have access to Specialist Palliative Care Advice via telephone support)

The Specialist Palliative Care Team are available to all health care professionals for telephone advice or will visit patients at home or in a hospice to offer clinical advice and guidance where needed. Patients are given contact numbers to gain direct access to the team.

11.1 Key Workers

The patient should be allocated a key worker, given their key workers contact details and the parameters of the key workers role. This should be clearly documented and communicated to the patient, carers and relevant professionals. The patient should be made aware if their key worker changes (which may well happen as the disease process develops). The key worker can be either a specialist or generalist (e.g. GP or District Nurse) with whom the patient has regular contact and who has received the relevant training and been assessed as competent.

Patients can also be admitted to their local hospitals or hospices for palliative and terminal care if appropriate. The members of the multidisciplinary Specialist Palliative Care Team are available to visit and advise on specific clinical difficulties.

www.dovehouse.org.uk
www.lindseylodgehospice.org.uk
www.standrewshospice.com
www.stcatherineshospice-nyorks.org
www.macmillan.org.uk

(For information regarding benefits / social care advice) Further information and details of Specialist Support Groups can be found on the NEYHCA (Cancer) website and in the Local Service Directory
11.2 Summary of Specialist Palliative Care Services Available Throughout the Region

10.21 Hull
- Marie Curie Nurses.
- Out of Hours nursing (East and West Hull)
- AHP services
- Palliative Care Consultant / out-patient clinic
- Lead Palliative Care Nurse
- Dove House Hospice (In Patients / Day Care / Lymphoedema)
- Community Palliative Care Macmillan / Clinical Nurse Specialists (CNS) - All P.C.T’s
- Hospital-based Palliative CNS Specialists
- GP Macmillan Facilitators
- Macmillan Day Care
- Chaplain / spiritual worker

11.22 Grimsby
- St Andrew’s Hospice (In Patients / Day Care / Lymphoedema / out of hours for North East Lincs.)
- Community Palliative Care Macmillan / CNS (All P.C.T’s)
- AHP services
- Palliative Care Consultant
- Hospital-based Palliative Care Macmillan / CNS
- Marie Curie Nurses – home nursing
- Lead GP x 2 / Nurse in Palliative Care
- GP Macmillan Facilitator
- Out of Hours Sitting Service
- Chaplain / spiritual worker

11.23 Scunthorpe
- Lindsey Lodge Hospice. (In Patients / Day Care / Lymphoedema / Breathlessness Clinic)
- Community Palliative Care Lead GP / CNS (All P.C.T’s )
- AHP services
- Hospital based Palliative Care Macmillan / CNS
- Specialist Palliative Care Social Worker
- Dedicated Occupational Therapy Service
- Dedicated Dietician
- Dedicated Pharmacist
- Marie Curie Nursing – North Lincs.
- Chaplain / spiritual worker

11.24 Scarborough
- St Catherine’s Hospice (In Patients / Day Care / Lymphoedema)
- Palliative Care Consultant / out patient clinic
- Community Palliative Care Macmillan / CNS (All P.C.T’s)
- AHP services
- Hospital-based Palliative Care Macmillan / CNS (Scarborough District General Hospital)
- GP Macmillan Facilitator
- Marie Curie Nursing
- Bereavement Support Services
- Chaplain / spiritual worker
11.25 Bridlington

- Macmillan Unit with ‘GP’ beds
- Neighbourhood Care Team (AHP services)
- Palliative Care Clinic
- Community Palliative Care CNS (All P.C.T’s)
- Chaplain / spiritual worker

(Plus all sites have Specialist Palliative Care Multidisciplinary Teams and all patients have access to phone support & advice)

12. Patient Information

General Guidance

“A higher priority should be placed on improving information for patients, face-to-face communication with health professionals and co-ordination and continuity of care. We also need to do more to support patients through their survivorship.”

Cancer Reform Strategy 2007

Patients should be offered a permanent record or summary of all consultations at which their treatment options are discussed, this should include clear verbal and written information about the following:

- The disease (on diagnosis)
- The nature and implications of diagnosis (where appropriate).
- The treatment options, and their effects (positive and adverse)
- Assessment of the outcome, and information on symptoms which may signify recurrence
- Relevant follow up (discharge) arrangements
- Information on patient involvement groups and support groups, including AHP support.
- If necessary, the patient should be offered a tape of their consultation

MDTs should be involved in patient exercises, in conjunction with Peer Review measures, to ascertain if patients have been offered:

- A key worker
- Information for patients and carers (written or otherwise)
- The opportunity of a permanent record or summary of consultation at which their treatment options were discussed

These exercises should be presented and discussed at MDT meetings, the teams should implement actions resulting from their findings.

Patient Information from National Information Pathways and local information meeting National Standards should be made available to all patients. Information should be available in languages and formats understandable by relevant local minority groups including; ethnic groups, those with alternative sexuality, and people with disabilities.

Information offered should be appropriate to the patients' needs at that point in their patient journey, (e.g. type of lesion, type of treatment, local services and any choice within them) and should be offered at all stages of the patient pathway. It should cover both physical and psychosocial issues. The information offered and given should be recorded in the patient notes.
Patient Information should include names and contact details of key personnel involved in the patients care. Upon diagnosis, every patient should be given the contact details of a key worker in line with local Key Worker Policy. A chemotherapy or oncology nurse should be available to advise, inform and support patients needing chemotherapy or radiotherapy.

Patients should have access to a team of professionals who have been trained in advanced communication skills. Emotional support should be available to the patient at any stage in their pathway of care. Patients should be encouraged to bring someone with them to provide support at diagnostic clinics / appointments at which distressing news may be communicated. Patients should be given time and support to reflect on their treatment options before having to make a decision. The service should have defined access to social workers, Allied Health professionals, chaplains, pain control and palliative care professionals, whether provided by hospital staff, the Hospices or within the Trust by the Special Palliative Care Team. Services should also aim to develop access to a range of psychological support and appropriate complimentary therapies.

Carers have a key role in supporting patients and may need information to enable them to fulfill this role optimally. However, patient-specific information should only be provided to carers within the context of protecting patient confidentiality and with the patient’s consent.

### CNS Contact Details

<table>
<thead>
<tr>
<th>Name</th>
<th>Hospital</th>
<th>Telephone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Chris Batty</td>
<td>Castle Hill Hospital, Castle Road, Cottingham, East Yorkshire, HU16 5JQ</td>
<td>01482 622013</td>
</tr>
<tr>
<td>Ms Terry Jemison</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms Jane Jenkinson</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms Philippa Robinson</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms Pam Hoyles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrs Sue Baker</td>
<td>Scarborough Hospital, Woodlands Drive, Scarborough, North Yorkshire, YO12 6QL</td>
<td>Bleep Switchboard 01723 368111</td>
</tr>
<tr>
<td>Mrs Sue Ledden</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrs Andrea Ward</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms Anne Thorne</td>
<td>Diana Princess of Wales Hospital, Scartho Rd Grimsby, N E Lincs, DN33 2BA</td>
<td>01472 874111 Extn 7729 and 2385</td>
</tr>
<tr>
<td>Ms Barbara Chaplin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ms Lisa Hall</td>
<td>Scunthorpe General Hospital, Cliff Gardens Scunthorpe, North Lincs, DN15 7BH</td>
<td>01724 282282</td>
</tr>
<tr>
<td>Ms Maxine Woollin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient Involvement Groups / Self Help Group information can be found on the NEYHCA website and in the Local Service Directory

Patient Information Pathway – details can be found on the NEYHCA website (Includes Social Care & Benefit Advice in the Local Service Directory)
Support Groups – details can be found on the NEYHCA website / Local Service Directory

[www.hyccn.nhs.uk](http://www.hyccn.nhs.uk)
13. Supportive Care Pathway

NEYHCA (Cancer) HIGH LEVEL SUPPORTIVE CARE PATHWAY

The pathway has four key components identified that would significantly improve the patient's experience:

- Holistic Assessment
- Key Discussion Point
- Single Contact with the assigned Key Worker
- Patient/carer information

Identified Key Components

<table>
<thead>
<tr>
<th>Stage on Pathway</th>
<th>Dependant On</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-referral and Screening Programmes</td>
<td>Accessible Health Promotion: Information Support and Advice from the Practice Nurses (and Triage if required). GP following NICE guidelines for timely referral.</td>
</tr>
<tr>
<td>1st GP/Symptoms Will include all access routes (A &amp; E, Emergency Admission, GP, Direct Access to tests etc)</td>
<td>GPs having the agreed timed site specific pathways using a symptom based approach to select the appropriate test / referral.</td>
</tr>
<tr>
<td>Diagnostic tests (MDT may occur after 1st test or later in the pathway)</td>
<td>Direct Access resources to tests can be carried out before referral (not 24/7). Requesting the appropriate test to inform diagnosis and practice staff having ability to offer support.</td>
</tr>
<tr>
<td>Diagnosis and staging Patient will be presented at MDT</td>
<td>Co-ordination of tests to reduce visits and adhere to agreed time scales. Core member attendance at MDT to facilitate next steps: referral to oncology etc to happen at MDT. Development of patient management plan.</td>
</tr>
<tr>
<td>Treatment planning options Decision to Treat: patient may need thinking time.</td>
<td>Timely patient hand-over of care with all relevant information. Communication with GP / Community Staff to enable timely &amp; effective primary care support.</td>
</tr>
<tr>
<td>Treatment Surgery, Chemotherapy, Radiotherapy, Watchful Wait</td>
<td>Timely patient hand-over of care with all relevant information. Communication with treatment Team &amp; GP / Community Staff to enable primary care support.</td>
</tr>
<tr>
<td>Living with Cancer Survivorship Recurrence/relapse suspected</td>
<td>Rapid access into secondary care for investigation of possible recurrence/further symptom management. Primary care to be aware when to re-refer.</td>
</tr>
</tbody>
</table>

At any stage of the pathway the patient referral for specialist palliative care input should be considered based on assessed need. If and when patients are assessed to have 6 – 12 months to live they will move onto End of Life pathway.

adapted from YCN supportive care pathway
### Appendices

#### Appendix (i) NEYHCA (Cancer) MDT meetings for Breast Cancer / Referral CCGs / Catchment Populations / Table of Key Contacts - April 2012

<table>
<thead>
<tr>
<th>Trust</th>
<th>Location</th>
<th>Urgent Referral</th>
<th>Day</th>
<th>Time</th>
<th>Lead Clinician</th>
<th>Clinical Nurse Specialists</th>
<th>Referring CCGs</th>
<th>Approx Total Population</th>
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<tbody>
<tr>
<td>North Lincolnshire and Goole Hospitals NHS Trust</td>
<td>via video conferencing between Diana, Princess of Wales Hospital Grimsby and Scunthorpe General Hospital</td>
<td>Tuesdays &amp; Fridays (weekly)</td>
<td>12.45 – 2.00</td>
<td>Miss Jenny Smith</td>
<td>Anne Thorne (DPOW)</td>
<td>NHS North Lincolnshire CCG</td>
<td>1,046,766</td>
<td></td>
</tr>
<tr>
<td>Hull and East Yorkshire Hospitals NHS Trust</td>
<td>Castle Hill Hospital</td>
<td>Tuesdays &amp; Fridays (weekly)</td>
<td>11.00</td>
<td>Scarborough Mr Ben Mancey Jones</td>
<td>Sue Baker</td>
<td>NHS Scarbrough and Ryedale)</td>
<td>290,010</td>
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<td>Hull and East Yorkshire Peter Kneeshaw</td>
<td>Sue Ledden</td>
<td>NHS Hull CCG</td>
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Population sizes are approximate. Source – NICE 2013
Appendix (ii) Management of Radioactive Clinical Waste arising from Sentinel Lymph Node Biopsy in Operating Theatres

Purpose
To ensure that the activity of radioactive waste produced during Sentinel Lymph Node surgery is sufficiently low to allow its disposal as non-active clinical waste in accordance with the Radioactive Substances Act 1993.

Introduction
Published work (1,2) on the radiation safety of the sentinel lymph node (SLN) technique, and local measurements on the clinical waste produced, have shown that the surgical swabs contain small amounts of radioactivity from absorbed blood. All other items of waste (gloves, drapes, probe cover) exhibit negligible radioactivity.

The standard practice for dealing with radioactive solid waste in the Nuclear Medicine Department is to store the waste on-site in a safe, segregated location for an appropriate period to allow its radioactive content to decay to a level at which disposal as non-active clinical waste is allowed.

To comply with this requirement when dealing with theatre waste, the simplest and most reliable system of work is to collect all swabs from SLN biopsy procedures and transfer them to the Nuclear Medicine Department for monitoring and storage prior to disposal.

Procedure
Staff must wear gloves at all times when handling surgical specimens, swabs and instruments.

The following procedure is to be performed during all SLN biopsy operations when the patient has previously received an injection of radioactive colloid, either on the day of surgery or on the day prior to surgery.

1. For each SLN patient, place all swabs (but no other clinical waste) into a small yellow clinical waste bag and secure.
2. Place the bag into a large plastic sharps bin identified for storage of SLN swabs.
3. When all the SLN cases have been completed, or the bin is full, close and secure the bin. Attach a warning tag (supplied by the Nuclear Medicine Dept) to the bin with a tie-wrap and record on the tag the date of surgery, the number of SLN patients and the theatre name/number.
4. The swab bin should be transferred to the Nuclear Medicine Department as soon as possible.
5. In the Nuclear Medicine Department, the swabs must be given directly to a member of staff and not left unattended in the Department.
6. If the transfer is to be made after 16:30 h, the Nuclear Medicine Dept should be telephoned to verify that a member of staff is available to receive the delivery.
7. Do not send the swabs to Nuclear Medicine if there is not a member of staff available to receive them. In that case, ensure that the swabs are stored overnight in a secure location where they will not be removed for routine clinical waste disposal.
8. Contact Nuclear Medicine the following morning and transfer the swabs as normal.

References
Appendix (iii) The Transport and Disposal of Radioactive Pathology Specimens Arising from Sentinel Lymph Node Surgery

Purpose

1. To ensure the safe and secure movement of radioactive surgical specimens between the operating theatre and the radiology department (for specimen radiography) and the pathology department (for histopathology)

2. To ensure that the disposal of pathology specimens from Sentinel Lymph Node surgery complies with the requirements of the Radioactive Substances Act 1993 for disposal as non-active clinical waste.

Introduction

From published work (1, 2) and local measurements of tissue samples, typically 99% of the injected radioactivity remains at the intradermal injection site. The sentinel lymph node (SLN) usually contains less than 1% of the total activity.

For purposes of radiation risk assessment, it may be assumed that the primary specimen contains 100% of the administered activity (e.g. a mastectomy specimen or a WLE specimen that contains the skin with the injection site) with a maximum of 5% in the excised SLNs.

The activities in the tumour specimen and SLN are significantly lower in cases when the tracer is administered on the day before surgery compared with same-day cases.

Procedures

1. General considerations when transporting specimens

   • The portering staff, the specimen radiographer and the pathology staff will receive only minimal radiation doses to the whole body and fingers as a result of handling the specimens, which should be treated as a biohazard rather than a radiation hazard.

   • The primary and SLN specimens should be placed in well sealed containers and labelled as arising from a SLN procedure. Radiation shielding of the containers is not required.

   • The loss of a specimen during transport should be reported to the Nuclear Medicine Department as soon as possible. Under the current Ionising Radiation Regulations (1999), it is not necessary to notify the HSE of the loss of such a low level of radioactivity.

2. Transporting specimens to the Pathology department

   The specimens are transported by road to the histopathology laboratory and it is necessary that this process complies with the Road Transport Regulations 2002

   Due to the low radioactive content of the specimens, they can be transported as excepted packages, for which the following requirements apply:

   • The specimen jars must be shipped within a container that is able to withstand routine transport conditions. (The standard aluminium transport cases are suitable)

   • When opened, the package must contain identification that the contents are radioactive.

   • An appropriate transport document must accompany the package

   There is no requirement to have external marking of the containers or the vehicle.

   Transport documents and labels can be obtained from the Nuclear Medicine Department.
3. Radioactive pathology waste

Radioactive material may be disposed of as routine clinical waste after a suitable period of storage to allow decay to a level of activity below a certain limit. This is specified in the authorisation issued to the appropriate hospital site under the Radioactive Substances Act 1993.

Storage for four days is sufficient to ensure that the highest activity specimen falls below this limit at time of disposal.

References

Appendix (iv) Guidelines for B3 Vacuum Assisted Biopsy

Abstract

Nationally the introduction of ultrasound-guided vacuum assisted biopsy (VAB) has led to an increase in the non-operative diagnosis of indeterminate (B3) breast lesions detected both by mammogram and ultrasound. Recently practices in the NEYHCA have evolved in line with current evidence-based research with vacuum assisted excision biopsy undertaken on a selected group of B3 lesions, with the aim to provide an effective, acceptable cost-efficient service which can be used as an alternative to surgery.

Introduction

In the UK, since the introduction of the National Health Service Breast Screening Programme (NHSBSP) there has been an increase in the number of small, radiologically indeterminate, non-palpable breast lesions detected at mammography\(^1,2\) that are also visible with ultrasound. With increasing technological advances increasingly smaller and more subtle lesions are detected, subjectivity in pathological description of breast histology\(^3\) means that many of the lesions have traditionally undergone surgical biopsy.\(^4\)

The use of 14-gauge needle core biopsy, combined with the introduction of large bore (11 or 8-gauge) vacuum-assisted biopsy (VAB) has led to an increase in non-operative diagnosis of such lesions.\(^5\)

The main advantage of the VAB, a technique which obtains contiguous samples, compared to the traditional 14-gauge needle core biopsy, is its superior ability to obtain an accurate histological diagnosis.\(^6\) VAB is also a less invasive procedure, is associated with less pain, with a quicker recovery time than the alternative open surgical biopsy.\(^7\) Research suggests that increasing expertise in the use of VAB means that there is now the potential to excise completely a small impalpable breast lesion.\(^8\)

VAB implies two major benefits: firstly better cosmesis for the patient\(^7\) - the incision needed for the largest (8-gauge) needle is 6mm as opposed to a much larger surgical scar, and secondly a cost benefit - disposables for a VAB procedure are cheaper than for the surgical alternative.\(^9\)

Initial diagnostic biopsies are taken using a 14-gauge spring loaded device, with only selected patients, discussed at MDT proceeding to VAB.

Working practices have developed in line with current research,\(^10\) with the entire mammographically or ultrasonically visible lesion being completely excised.

The results of the mamotome audit 2003-05 and preliminary results of the follow up study can be found in Appendix A

Management Protocols for B3 Subgroups

B3 lesions No atypia at VAB

This category includes Radial Scars and papillary lesions in both post-menopausal and pre-menopausal women. If the MDT discussion is concordant after VAB excision of the mammographically or ultrasonically visible lesion, with no histological atypia, the patient can be discharged to either routine recall or symptomatic discharge.\(^\)

*NHSBSP guidelines No. 49 2005 accept VAB for the excision of Radial Scar & papillary lesions*
**B3 lesion with atypia at VAB**

This category includes ADH, non pleomorphic LCIS / lobular neoplasia, & any of the above categories with atypia. If the MDT decision is concordant patients from this category are managed appropriately (see flow diagrams):

**B3 of uncertain potential on 14-gauge core biopsy**

1. **ATYPIA on 14g core**
   - Mammothome Biopsy
     - Upgrade to B4 or B5
     - Remains B3 ADH
     - B2 Discuss follow-up at MDT
       - Annual mammographic follow up for 3 years if consensus agreement at MDT (then return to routine recall if applicable)
       - Discharge or return to routine recall breast screening

2. **Papillary lesion on 14-gauge biopsy**
   - Under 10mm
     - Mammothome excision if accessible
       - Upgrade to B4 or B5
       - Surgery
     - Remains B3
   - Over 10 mm or multiple papillary lesions
     - Surgical excision
     - B2
       - Annual mammographic follow up for 3 years if consensus agreement at MDT
       - Discharge or return to routine recall breast screening
B3 lesion with significant atypia

Any B3 lesion pathologically reported as having a high degree of atypia with a discordant MDT decision should proceed to surgical biopsy.

Rationale

Current evidence based practice suggests that 14g core biopsy followed by vacuum-assisted biopsy, such as the mammotome biopsy, has led to an increase in the non-operative diagnosis of small breast lesions. For a select group of patients this practice may allow the patient to undergo a less invasive procedure therefore reducing scarring in comparison with a surgical procedure. There is, however, some debate regarding the excision vs. sampling of the B3 lesion as, it is recognised that there may be an upgrade to carcinoma related to the pathological degree of atypia, with some papers suggesting that a surgical biopsy rather than mammotome excision biopsy should be undertaken to exclude malignancy.

Controversy exists as to whether the mammotome, or any other vacuum assisted device, has the potential to eliminate the need for surgery. Psychological distress could be caused to patients in whom a breast cancer has been underestimated, with implications in the delay of establishing a definitive diagnosis and hence appropriate treatment. However, with increasing expertise in operator use of the Mammotome biopsy a potential has developed to completely excise small impalpable breast lesions. Each case must be individually assessed at MDT with a consensus that the initial core biopsy does not show evidence of malignancy.

Trends demonstrate Vacuum Assisted excisional biopsy is safe practice providing the criteria below are discussed at MDT:

- Type of B3 lesion
- Degree of atypia
- Extent of Mammotome excision
- Family history (symptomatic younger women)
References


5. Evans A. “Clinical cases covering management of borderline lesions” Breast cancer research 8(suppl1) P12 2006


Appendix A

Results of Mammotome (VAB) audit 2003-5

Key:
- RR = Routine recall
- NSR = No sign of recurrence
- F/U = Follow up
- INV CA = Invasive cancer

2005 Study - Range of incidence of cancer in B3 category = 3.6 to 6.3%

Preliminary results of follow up study 2005-08

61 B3 patients followed up for 3 years
- 28 = Routine recall
- 3 = Assessed to routine recall
- 9 = under care: no sign recurrence
- 21 = lost to study (died/over screening age/DNA screening)

- 9 patients followed up symptomatically every year for 3 years: No evidence of mammographic recurrence
- 3 patients reassessed at 3 year screen: No evidence of mammographic recurrence

No cases so far progressing to Cancer 2005-08
Appendix (v) Treatment Algorithms for Breast Cancer (Click on Link Below)

Neo-Adjuvant & Adjuvant Treatment

In patients who would benefit from first line chemotherapy the following algorithm should be used.

http://www.hyccn.nhs.uk/NetworkGuidelinesAndPublications/ChemotherapyAndPharmacy.htm

Metastatic Breast Cancer

http://www.hyccn.nhs.uk/NetworkGuidelinesAndPublications/ChemotherapyAndPharmacy.htm
Appendix (vi) Hull and East Yorkshire Hospitals NHS Trust Survivorship Plan

Process
Patients will be given a year one clinic appointment with a mammogram at the post-operative results consultation. At this appointment, if clinical review and mammogram are normal, the clinician will enter the patient into the nurse led breast care follow up programme, completing the medical management and support plan, (Appendix A). The patient completes a self-assessment questionnaire, (Appendix B) prior to holistic needs assessment undertaken by the breast care nurse (Appendix C). An agreed personalised management and support plan is then produced based on the needs of the patient. A patient information leaflet (Appendix D) explaining access to the service and symptoms to report is provided at this appointment.
Copies of the agreed plan are given to the patient, their GP and retained in the breast care nursing and medical notes.

A data collection form and associated data bases are completed to instigate the annual mammographic recall surveillance, the holding list for five year discharge and stratification of the patients into level of care required (Appendix E)

On the rare occasion that a patient refuses to take part in the breast care follow up programme, traditional follow up will continue until discharge at 5 years
If a patient fails to attend (DNA) the Breast Care Follow Up one year holistic assessment, this is recorded in the medical notes and a further appointment sent. One further DNA results in the patient being reappointed to traditional combined clinic follow up for year 2 with mammogram on arrival. If a patient fails to keep a telephone follow up appointment, no further appointment will be made.

During years 2 -5 patients can access breast services via the breast care nurse telephone line. Clinic appointments or referrals can be made as required following the telephone assessment. Subsequent data forms see appendix F, are completed for each intervention. All services listed on the data collection sheet accept direct referrals from the breast care nurses.

Follow up by the BCN either face to face or telephone may be arranged at initial assessment or at subsequent times. Clinic appointments are available for such contacts and this activity recorded on data sheets. If a patient requires assessment in any of the breast clinics, the BCN will use the G2 system to ensure a letter is available for the medical staff via Patient Centre. The Breast Care Nurse should be copied in to the outcome letter from the clinic consultation.

Any patients requiring investigations or having an abnormal mammogram will be discussed at MDT and assessed in a combined clinic if required. In the event of recurrent or metastatic disease, MDT outcome will be sent to mammographic recall service the patient will be withdrawn from the programme.
If a patient is diagnosed with an unrelated primary cancer they will be assessed on an individual basis as to the appropriateness of the breast cancer follow up programme.
Patiens requiring a ‘switch’ of endocrine therapy at either two or three years should have this recorded clearly on the initial management plan by the clinician.

All patients remaining on the programme return to the combined clinic at year 5 and have a mammogram on arrival and further assessment by the clinician and BCN prior to being discharged. Further supporting written information will be given at this assessment.
Process for Monitoring Compliance
Annual audits will be carried out by the Breast MDT with feedback to the Breast Business and Governance Meetings

Monthly key performance indicator (KPI) reports and fed back to the Business and Governance Meetings

Action plans to be developed and implemented from findings by the Breast MDT
Clinical lead for Breast Care Follow up Programme to be responsible for implementation of actions and dissemination of findings locally and nationally if appropriate.

Objectives
- To provide an individualised follow up plan.
- To detect recurrence or new disease.
- To reduce long term effects of a breast cancer diagnosis and cancer treatments.
- To reduce unnecessary regular attendance for clinical follow up
- To improve the patient’s quality of life enabling them to return to normality

Outcomes
- Reduce demand on other services due to unmet needs.
- Timely intervention for recurrent or new disease.
- To increase financial and physical capacity.
- To improve recovery and quality of life.

Patients will be entered into the breast care nurse-led follow up programme by the Clinician.

Inclusion criteria
All patients who have undergone treatment for breast cancer with curative intent are eligible if the year one mammogram is normal (patients over the age of 80 years will be given the option by the clinician as to whether they partake in mammographic surveillance and this will be recorded on the management plan).

Exclusion criteria
Year one mammogram abnormality
Patients who have, or are being investigated for metastatic disease.
Patients without mental capacity.
Non compliant patients.
Patients unable to converse in English.
Patients having primary endocrine therapy.
Clinician discretion.

References
Cancer Research UK (2009)
### Patient Demographics:

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<th>Medical Management Plan</th>
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#### Management plan initiated by:

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#### Treatment summary:

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<tr>
<td>Radiotherapy Y / N</td>
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<tr>
<td>Herceptin Y / N</td>
<td></td>
</tr>
<tr>
<td>Endocrine therapy:</td>
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#### Your radiological follow up requirements:

#### Your endocrine therapy needs to be reviewed in:

#### Ongoing services or treatment that you will be receiving:

### Personal Management and Support Plan
**Assessment completed by:**

<table>
<thead>
<tr>
<th>Name of Breast care Nurse :</th>
<th>Signature:</th>
<th>Date:</th>
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</thead>
</table>

You have identified the following key concerns, care needs or goals that you would like to see addressed, improved or achieved:

1. 
2. 
3. 
4. 
5. 

**Services you have been referred to**


**Healthy lifestyle advice that has been given to you:**


**Information given to you:**


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## Breast Cancer Follow-Up Assessment Record

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### Assessment completed by:

**Diagnosis and Treatment Summary**

No concerns identified □

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<th>Patient</th>
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### Physical Concerns

### Practical Concerns

### Family/relationship Concerns

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<td>Emotional Concerns</td>
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<td>Spiritual or religious Concerns</td>
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<td>Lifestyle or information needs</td>
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<td>Strategy agreed with patient for reporting future concerns or fears</td>
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**Referrals made to services:**

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<td>GP/Practice nurse</td>
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<tr>
<td>Research nurse</td>
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<tr>
<td>Dietician</td>
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</tr>
<tr>
<td>Therapists - Physio/OT</td>
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<tr>
<td>Lymphoedema nurse specialist</td>
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<td>Information Services</td>
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<td>Oncology</td>
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<tr>
<td>Financial/ Benefits Advice Service</td>
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<td>Social Worker</td>
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<td>Psychologist/ Oncology Health Centre</td>
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<tr>
<td>Local Self Help/ Support Group</td>
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<td>District Nurse</td>
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</tr>
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<td>Holistic/ Complementary Therapy Services</td>
<td>Referred to Oncoplastic clinic.</td>
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</tr>
<tr>
<td>Community/ Palliative Care team</td>
<td>Other</td>
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</table>

**Signature:**

**Print name:**

**Date & Time:**
## Breast Care Follow Up. Data Form 1 – Assessment

Please affix patient label here

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<th>First assessment</th>
<th>Follow up consultation</th>
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</thead>
</table>

### Type of contact
- Clinic consultation
- Telephone consultation

### Details
- **Consultant:**
- **Oncologist:**
- **Assessed / contact by Breast Care Nurse (BCN):**

### Medical Details
- **Mammogram / monitoring date:**
- **Five year discharge date:**
- **Endocrine review date:**
- **N/A:**
- **Date of next appointment:**
- **Who appointment with:**

### Ongoing Treatment
- **Endocrine**
- **Herceptin**
- **Contact with BCN**
- **Research Nurse**

### Outcome of Consultation

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<td>Avoided unnecessary / non required attendance</td>
</tr>
<tr>
<td>A2</td>
<td>Referred into appropriate clinic</td>
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<tr>
<td>B</td>
<td>Information &amp; psychological support provided</td>
</tr>
<tr>
<td>D1</td>
<td>Lymphoedema service</td>
</tr>
<tr>
<td>D2</td>
<td>Community / Palliative Macmillan team</td>
</tr>
<tr>
<td>D3</td>
<td>Local support group / self help</td>
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<td>D5</td>
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</tr>
<tr>
<td>D6</td>
<td>Financial / benefits advice</td>
</tr>
<tr>
<td>D7</td>
<td>Oncoplastic services</td>
</tr>
<tr>
<td>D8</td>
<td>Information services</td>
</tr>
<tr>
<td>D9</td>
<td>Complementary services</td>
</tr>
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<td>D10</td>
<td>Home from Hospitals</td>
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<tr>
<td>D11</td>
<td>GP / Practice Nurse</td>
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<td>Oncology</td>
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<td>D14</td>
<td>Ward</td>
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<tr>
<td>D15</td>
<td>Social worker</td>
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<tr>
<td>D16</td>
<td>Research nurse/study</td>
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<td>D17</td>
<td>Prosthetic service</td>
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### Self Management
- **Primary cancer. Date:**
- **Recurrence. Date:**

### Shared Care
- **Curative intent. Date:**
- **Metastatic cancer. Date:**

### Complex Care
- **Palliative Care. Date:**

### Additional Information
- **Treatment completed:**

---

*Guidelines for the Management of Adult Breast Cancer Patients Version 3.8a January 2014 | Page 63*
Breast Care Follow Up.  

Data Form 2 - Follow Up

Please affix patient label here

Date of contact ...............  
Follow up consultation

Type of contact :  Clinic consultation ☐  Telephone consultation ☐

Consultant..................  Contact by Breast Care Nurse (BCN) ......................

Date of next appointment ...............  Who appointment with ......................

Ongoing treatment :  Endocrine ☐  Herceptin ☐  Contact with BCN ☐  Research Nurse ☐

<table>
<thead>
<tr>
<th>Code</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
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<td>A2</td>
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<td>B</td>
<td>Information &amp; psychological support provided</td>
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<td>D1</td>
<td>Lymphoedema service</td>
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<td>D2</td>
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<td>GP / Practice Nurse</td>
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<td>Oncology</td>
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<td>Ward</td>
</tr>
<tr>
<td>D15</td>
<td>Social worker</td>
</tr>
<tr>
<td>D16</td>
<td>Research nurse/study</td>
</tr>
<tr>
<td>D17</td>
<td>Prosthetic service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>D17</td>
<td>Other</td>
</tr>
</tbody>
</table>

Self management ☐  Duration of contact ............... minutes  Recurrence. Date.............

Shared care ☐  Metastatic cancer. Date.............

Complex care ☐  Palliative Care. Date.............

Additional Information
This is a step by step approach to monitoring.
The first row gives instruction on possible content and what to think about for each column. The second row gives possible headings for the final document. How the detail is presented is up to each organisation. This table is not obligatory it is purely to give clarity for authors on steps to achieve monitoring, how and where monitoring has identified deficiencies and how to demonstrate evidence that resultant recommendations have been actioned through structured plans culminating in changes in practice(s) and the sharing of lessons learned. The third row includes some suggested generic wording as particularly actions and changes cannot be identified in advance.

<table>
<thead>
<tr>
<th>What key element(s) need(s) monitoring as per local approved policy or guidance?</th>
<th>Who will lead on this aspect of monitoring? Name the lead and what is the role of the multidisciplinary team or others if any.</th>
<th>What tool will be used to monitor/check/observe/asses/inspect/authenticate that everything is working according to this key element from the approved policy?</th>
<th>How often is the need to monitor each element?</th>
<th>Who or what committee will the completed report go to? How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes?</th>
<th>Which committee, department or lead will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes?</th>
<th>How will system or practice changes be implemented the lessons learned and how will these be shared.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Element to be monitored</td>
<td>Lead</td>
<td>Tool</td>
<td>Frequency</td>
<td>Reporting arrangements</td>
<td>Acting on recommendations and Lead(s)</td>
<td>Change in practice and lessons to be shared</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

| | | | | | | |
| | | | | | | 

Individualise the timeframe(s)

The lead or committee is expected to read and interrogate the report to identify deficiencies in the system and act upon them.

Required actions will be identified and completed in a specified timeframe.

Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
Hull & East Yorkshire Breast Care Follow up (primary cancer) - Overview March 2012

Definitions
Survivorship – living with and beyond cancer.

Appendix (vii) Names and Roles of the Breast CEG Members (Updated 30.4.2012)

<table>
<thead>
<tr>
<th>Hull and East Yorkshire Hospitals NHS Trust</th>
<th>Hull and East Yorkshire Hospitals NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Augustine Akali</td>
<td>Consultant Plastic &amp; Reconstruction Surgeon</td>
</tr>
<tr>
<td>Ms Deborah Allanson</td>
<td>Oncology Lymphoedema Nurse Specialist</td>
</tr>
<tr>
<td>Mrs Sarah Bates</td>
<td>Nurse Manager / Trust Lead Nurse</td>
</tr>
<tr>
<td>Ms Chris Batty</td>
<td>Macmillan Breast Care Nurse Specialist</td>
</tr>
<tr>
<td>Mrs Tracey Boyce</td>
<td>MDT co-ordinator/data manager</td>
</tr>
<tr>
<td>Ms Caroline Bradley</td>
<td>Consultant Radiographer</td>
</tr>
<tr>
<td>Dr Mohammad Butt</td>
<td>Consultant in Medical Oncology</td>
</tr>
<tr>
<td>Dr Amandeep Dhadda</td>
<td>Consultant Clinical Oncologist</td>
</tr>
<tr>
<td>Mr Kartikae Grover</td>
<td>Consultant Breast Surgeon</td>
</tr>
<tr>
<td>Ms Elaine Gullaksen</td>
<td>Research Nurse</td>
</tr>
<tr>
<td>Mrs Carol Hodson</td>
<td>Chemotherapy Lead Nurse</td>
</tr>
<tr>
<td>Mrs Lynne Horton</td>
<td>Nurse Practitioner for Breast</td>
</tr>
<tr>
<td>Miss Pamela Hoyles</td>
<td>Macmillan Breast Care Nurse Specialist</td>
</tr>
<tr>
<td>Dr Anne Hubbard</td>
<td>Consultant Radiologist</td>
</tr>
<tr>
<td>Dr Naila Ihsan</td>
<td>Associate Specialist in Breast Surgery</td>
</tr>
<tr>
<td>Ms Terry Jemison</td>
<td>Macmillan Breast Care Nurse Specialist</td>
</tr>
<tr>
<td>Ms Jane Jenkinson</td>
<td>Macmillan Breast Care Nurse Specialist</td>
</tr>
<tr>
<td>Mr Peter Kneeshaw</td>
<td>Consultant Breast Surgeon</td>
</tr>
<tr>
<td>Ms Dot Littlewood</td>
<td>Specialist Practitioner</td>
</tr>
<tr>
<td>Mr Tapan K Mahapatra</td>
<td>Consultant General and Breast Surgeon</td>
</tr>
<tr>
<td>Miss Penelope McManus</td>
<td>Consultant Breast Surgeon</td>
</tr>
<tr>
<td>Mr Martin Gomersall</td>
<td>Business Manager</td>
</tr>
<tr>
<td>Dr Penny O'Neill</td>
<td>Consultant in Medical Oncology</td>
</tr>
<tr>
<td>Mrs Margaret Parrott</td>
<td>Trust Lead Cancer Manager</td>
</tr>
<tr>
<td>Dr Ayesha Rahman</td>
<td>Consultant Radiologist</td>
</tr>
<tr>
<td>Ms Philippa Robinson</td>
<td>Macmillan Breast Care Nurse Specialist</td>
</tr>
<tr>
<td>Mrs Janet Shipley</td>
<td>Cancer Quality Measures Manager</td>
</tr>
<tr>
<td>Dr Saiqa Spensley</td>
<td>Consultant Clinical Oncologist</td>
</tr>
<tr>
<td>Heather Hayden</td>
<td>Divisional General Manager Family &amp; Women's Health Group</td>
</tr>
<tr>
<td>Dr Sunil Upadhay</td>
<td>Consultant Clinical Oncologist</td>
</tr>
<tr>
<td>Dr Joanna Wieczurek</td>
<td>Consultant Radiologist</td>
</tr>
<tr>
<td>Ms Helen Wright</td>
<td>Cancer Research Business Manager</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Northern Lincolnshire and Goole Hospitals NHS Foundation Trust</th>
<th>Northern Lincolnshire and Goole Hospitals NHS Foundation Trust - continued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Kay Burns</td>
<td>Macmillan Dietician</td>
</tr>
<tr>
<td>Ms Barbara Chaplin</td>
<td>Breast Care Nurse Practitioner</td>
</tr>
<tr>
<td>Ms Rachel Cubbison</td>
<td>Breast Unit Manager, Advanced Practitioner</td>
</tr>
<tr>
<td>Ms Kathy Dent</td>
<td>Lead Research Nurse</td>
</tr>
<tr>
<td>Mr Leslie Donaldson</td>
<td>Consultant Breast Surgeon</td>
</tr>
<tr>
<td>Mr Anthony Fitzgerald</td>
<td>General Manager</td>
</tr>
<tr>
<td>Ms Lisa Hall</td>
<td>Clinical Nurse Specialist for Breast</td>
</tr>
<tr>
<td>Miss Louise Hobson</td>
<td>Trust Cancer Manager</td>
</tr>
<tr>
<td>Ms Claire Jenkinson</td>
<td>Assistant General Manager</td>
</tr>
</tbody>
</table>
Appendix (vii) The Breast CEG Executive Team

Chair
Mr. Kartikae Grover  Consultant Breast Surgeon HEYHT

Vice Chair
Miss Jenny Smith  Consultant Breast Surgeon, NLGHFT

MDT Leads
Miss Penny McManus  Consultant Breast Surgeon HEYHT CHH
Miss Jenny Smith  Consultant Breast Surgeon NLGHFT DPOW
Mr Ben Mancy-Jones  Consultant Breast Surgeon SNEYHT / YORK

Member Responsible for User / Patient Information
Ms Jane Jenkinson  Macmillan CNS HEYHT CHH

Member Responsible for the integration of Service Improvement
Mr Peter Kneeshaw  Consultant Breast Surgeon HEYHT CHH

Member Responsible for Recruitment into Clinical Trials
Dr Saiqa Spensley  Consultant Clinical Oncologist HEYHT CHH
Guidelines Agreed (Clinical, Imaging & Pathology)

Agreement of the North East Yorkshire & Humber Clinical Alliance (Cancer) Guidelines for the Management of Adult Breast Cancer Patients by the Breast Clinical Expert Group

These guidelines were developed by the former Breast Network Site Specific Group (NSSG), taking into account NICE Guidance and the IOG, and are the standard for care across the Clinical Alliance. They were discussed and circulated within the group as per the NEYHCA (Cancer) consultation process. All members were given the opportunity to assist in the publication of the guidelines / comment. The Guidelines were formally agreed by the Breast NSSG, at a quorate meeting. Those present at the meeting agreed the document on behalf of the group. Those not present at the meeting accept the groups’ decision. The groups’ attendance record for the meeting where the guidelines were agreed can be seen below. The guidelines agreement sheet was then signed by the Chair, MDT Leads, Network Imaging group Chair and Network Pathology Group Chair. The guidelines were then be presented to the former Cancer Network Board and the Network Medical Director who also signed the agreement sheet.

The guidelines were deemed to be read and agreed by the NSSG at the meeting on the 22nd of October 2009. Some amendments were made to the guidelines following the October 2009 NSSG meeting. These amendments were emailed out to the whole group, in line with the network consultation process. These amendments and the imaging guidelines were agreed by the group in January 2010 and by the CNB in April 2010 (version 3.5).

Following Peer Review 2010 the group was asked to review some sections of the guidelines. These amendments were discussed at an extraordinary NSSG meeting on the 21st January 2011. Further meetings were held on the 18th and 31st of March 2011. The reviewed guidelines were finally agreed at the NSSG on the 12th of April 2011. The guidelines were then agreed by the CNB on the 25th of May 2011.

These guidelines were reviewed in January 2013, agreed by the group via email in February 2013.
## Sign Off Sheet

<table>
<thead>
<tr>
<th>Agreement of the NEYHCA (Cancer) Guidelines for the Management of Adult Breast Cancer Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title</strong></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Chair of NEYHCA Board / Cancer Management Group (CMG)</th>
<th>Mrs Allison Cooke</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Chair of the Breast CEG</th>
<th>Mr Kartikae Grover, Consultant Breast Surgeon</th>
</tr>
</thead>
</table>

*Please see original signature sheet*

<table>
<thead>
<tr>
<th>Clinical Lead, Scarborough and North East Yorkshire Healthcare NHS Trust</th>
<th>Dr Sam Khulusi</th>
</tr>
</thead>
</table>

*Please see original signature sheet*

<table>
<thead>
<tr>
<th>Clinical Lead, Hull and East Yorkshire Hospitals NHS Trust</th>
<th>Dr Stuart Baugh</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Chair of the NEYHCA (Cancer) Imaging Clinical Expert Group</th>
<th>Dr Ged Avery</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Chair of the NEYHCA (Cancer) Pathology Clinical Expert Group / Medical Director NEYHCA</th>
<th>Dr Carol Hunt</th>
</tr>
</thead>
</table>

These Guidelines have been agreed by the Breast Clinical Expert Group