Clinical Focus: Breast Cancer

NEW STANDARDS FOR CARE IN BREAST CANCER

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BACKGROUND

Breast cancer is currently the cause of 13,000 deaths per annum in England and Wales with variable death rates across the country.

Radical changes for the delivery of care to women with breast disease, as advocated in the Calman Hine report⁽¹⁾, are now being put into practice. The aim is to ensure that services capable of delivering consistently good outcomes are available to all women with breast cancer.

Guidance to purchasers has been produced by the NHS executives, independent of any specialist medical group, and based on objective evidence^(2,3). Purchasers, professional bodies and patients' representatives were given an opportunity to comment at an early stage. The impact of these guidelines will vary across the country, depending on the current services, but overall this is expected to require some additional investment.

The framework described closely mirrors that set up for the Forrest Breast Screening Programme.

There are five key recommendations:

- 1 provision of specialist breast care teams
- 2 better communications with the patient
- 3 diagnosis using triple assessment
- 4 more selective routine follow-up
- 5 monitoring of outcomes

These recommendations encompass eleven topics:

- 1 Rapid and accurate diagnostic services
- 2 Patient-centered care
- 3 Surgery
- 4 Radiotherapy
- 5 Systemic therapy
- 6 Patient follow-up
- 7 Palliative care
- 8 Specialist breast care team
- 9 Effective interprofessional communication
- 10 Clinical guidelines, up-to-date practice and continuing professional development
- 11 Environment and facilities

Rapid access to diagnostic services by a specialist breast care team with triple assessment

A multi-disciplinary team consists of breast care surgeons, who should be members of BASO, the British Association of Surgical Oncologists, pathologists, radiologists, a breast care nurse and radiographers. These personnel should work within written guidelines with a total unit through-put of at least one hundred new breast cancer cases per year. Triple assessment involves diagnosis using a combination of clinical examination, radiological investigation with mammography and/or ultrasound and tissue sampling by either fine needle aspiration cytology (FNAC) or core biopsy. These are performed at the initial clinic visit. The breast care nurse should be available at that time. The results of all tests should be communicated to the patient within five working days. Diagnostic surgical biopsy is performed when triple assessment does not yield a definitive result. The radiological facilities and imaging should fulfil the same quality assurance criteria as those for the Forrest NHS Breast Screening Project⁽⁴⁾. There is good evidence that triple assessment increases the accuracy and decreases the overall cost of diagnosis when compared to the selective use of the

Fig. 1 – Typical breast carcinoma with a spiculated margin

component tests. Triple assessment is highly cost-effective. The addition of fine needle aspiration to routine clinical examination and mammography should decrease the open biopsy rate, with more patients having a single therapeutic surgical procedure. Complete accuracy of pathological reporting is required with information on tumour type, pathological size, histological grade, oestrogen receptor status, vascular invasion, extent of ductal carcinoma *in situ*, tumour margins and lymph node status. This information should be forwarded to the cancer registry.

Patient-centered care

Patient-centered care must minimize delay at all stages of diagnosis and treatment because there is evidence that delay is a major cause of anxiety. The breast unit should have clear, specific guidelines for rapid referral from GPs. BASO gives guidelines for timing at all stages:

- 1 GP referral to outpatient visit
- 2 Initial outpatient visit to cytological or histological diagnosis
- 3 Diagnosis to definitive treatment

It is also recommended that clear verbal and written information is given to patients at every stage during their management, with information being available in appropriate languages for ethnic minorities. It is desirable that members of the team involved in clinical care are trained in communication and counselling skills to enable them to communicate effectively with patients.

Psychological support to patients and their families should be available at all stages after the initial referral.

There should be provision for data collection from the time of referral:

- 1 To outpatients
- 2 To diagnosis
- 3 To surgery

in keeping with the BASO guidelines. Resource implications include purchase of information leaflets, provision of patient surveys and training of staff in communication and counselling skills.

Reduced patient follow-up

There is evidence that routine hospital follow-up after primary treatment for cancer of the breast does not improve survival and can cause increased anxiety. The majority of cases of local recurrence are detected by women between follow-up consultations. Routine tests to detect metastases are unnecessary as there is no evidence that these will lead to improved survival. Regular mammographic surveillance to detect local recurrence of cancer in the treated breast and a second primary in the other breast, (both of which have an increased incidence when compared with the general population) is advised. Accepted practice is that all women who have been treated for breast cancer undergo follow-up with mammography annually for five years following primary treatment and thereafter every two years.

The recommendation is that:

- 1 At the end of primary treatment the patient and specialist

agree a written care plan.

- 2 Intensive follow-up should not be offered by the breast unit as routine, but patients should have an easy access route back into the breast clinic, either directly or via the breast care nurse.
- 3 All patients undergo follow-up mammography to look for local recurrence or a second primary in the other breast.
- 4 Under protocols for some clinical trials there may be some need for continued follow-up by the breast team. The advantages of minimal follow-up are a reduction in anxiety in patients and also a decrease in pressure on the breast clinic, making more time available to the patients who most need specific specialist care.

How are local clinicians responding to the Calman Hine report?

Clinicians working in Lancaster and Kendal currently see 170 new breast cancer cases per year. For the purposes of Calman accreditation, the two trusts are considered together. Patients are seen by two designated breast surgeons, Mr. John Abraham and Mr. Wyn Morgan. In Lancaster the plan is to set up a symptomatic breast clinic based in the current breast screening clinic. This will bring members of the specialist breast team together from all disciplines under one roof. We intend to run this as a rapid access combined symptomatic and assessment clinic. Patients will undergo 'triple assessment'. This involves:-

- 1 Clinical assessment and examination by a surgeon.
- 2 Radiological investigation using mammography and/or ultrasound.
- 3 Cytological or histological sampling with either fine needle aspiration or a true cut core biopsy for pathological diagnosis.

The breast care nurse will be present throughout the clinic.

We plan to formalise the weekly case review meeting that is currently held for patients with screen-detected cancer to include all breast cases. This brings together pathologists,

Patient Group	Routine Follow up
Ductal Carcinoma <i>in situ</i> (DCIS)	Hospital for 7 years Mammography annually for 7 years GP annually to 75
Stage 1 and 2 (early) Breast Conservation	Hospital for 2 years Mammography annually for 5 years then every 2 years to 75 (to be arranged by hospital) GP for 5 years or age 75
Stage 1 and 2 Mastectomy	Hospital for 2 years Mammography every two years to 75 (to be arranged by hospital) GP for 5 years or age 75
Stage 3 and 4 (Advanced)	Hospital and GP indefinitely

radiologists, surgeons and the breast care nurse. The results of radiological investigations and pathology are discussed in context with the clinical findings. At this stage a plan for appropriate further management of the patient is suggested. Results should be available to the patient within five working days.

How should GPs use this service?

Criteria for an appointment at the rapid access clinic include:

- 1 Age greater than 35 years
- 2 A palpable lump
- 3 Nipple discharge
- 4 New nipple inversion
- 5 Paget's disease of the nipple

Protocols are currently being used for the management of both benign and malignant breast disease.

Data collection to support this is needed to the same level as that provided by the NHS breast-screening programme. BASO supplies a computer programme which is currently in place but is not yet complete. We intend to appoint a person with the appropriate skills to this new post.

We plan to implement the changes recommended for follow-up. We suggest the following protocol for the follow-up of patients with breast cancer.

Exclusions:-

- 1 Patients in a clinical trial
- 2 Patients with recurrent disease
- 3 Patients with a breast cancer gene mutation

Monitoring outcomes by the purchaser requires:-

- 1 Routine audit.
- 2 An infrastructure capable of collecting data about patients, investigation of disease, treatment and outcomes. Systemic reporting and recording of pathology data is essential in this, as is access to accurate cancer registry data. Changes will need to be made as this information is currently only available in a fragmented form.

The opening of the radiotherapy centre in Preston and the appointment of a radiotherapist locally with responsibility for Morecambe Bay patients will improve the service. Currently, the prospect of travelling to the Christie Hospital in Manchester for radiotherapy does influence some patients to choose mastectomy instead of breast conservation.

Local response to the Calman report will bring together specialists already involved in the management of breast cancer, to streamline the route through investigation and treatment. A combination of all these changes will significantly improve the quality of patient care.

REFERENCES

- 1 A Policy Framework for Commissioning Cancer Services – report of the Expert Advisory Group on Cancer 1996
- 2 Improving Outcomes in Breast Cancer – The Manual (96 CC 00 22)
- 3 Improving Outcomes in Breast Cancer – The Research Evidence (96 CC 00 22)
- 4 The Royal College of Radiologists. Quality Assurance Guide for Radiologists. NHS BSP Publication 1990