

Optimal care pathway for people with breast cancer

Quick reference guide



Support: Assess supportive care needs at every step of the pathway and refer to appropriate health professionals or organisations.

The optimal care pathways describe the standard of care that should be available to all cancer patients treated in Australia. The pathways support patients and carers, health systems, health professionals and services, and encourage consistent optimal treatment and supportive care at each stage of a patient's journey. Seven key principles underpin the guidance provided in the pathways: patient-centred care; safe and quality care; multidisciplinary care; supportive care; care coordination; communication; and research and clinical trials.

This quick reference guide provides a summary of the *Optimal care pathway for people with breast cancer*.

Please note that not all patients will follow every step of the pathway.

Step 1: Prevention and early detection

Risk factors

See the **optimal care pathway for people with breast cancer** for a comprehensive list of risk factors for developing breast cancer.

Prevention

Recommendations that may assist in preventing breast cancer include the following:

- Maintain a healthy weight.
- Avoid or limit alcohol intake.
- Get regular exercise.
- Avoid or limit use of hormone replacement therapy.
- Consider additional prevention strategies in people with increased risk (e.g. gene mutation carriers).

Individual risk assessment will help guide additional prevention strategies.

Risk reduction

For women with an increased risk of breast cancer, anti-hormonal risk-reducing medication lowers risk. Women at very high risk may consider risk-reducing surgery.

Risk assessment tools

Assessing a patient's personal breast cancer risk will help guide appropriate strategies.

Validated computerised breast cancer risk assessment tools that estimate a woman's breast cancer risk include:

- iPrevent <<https://www.petermac.org/iprevent>>
- IBIS tool <<https://ibis.ikonopedia.com>>
- CanRisk Web Tool <<https://canrisk.org/>>.

Screening recommendations

- Breast awareness
- BreastScreen Australia offers 2-yearly mammographic screening targeted at asymptomatic women aged 50–74 (although women over age 40 can attend on request).
- A doctor's referral is not required for this screening, but a GPs' encouragement is a key factor in participation.

Women invited to screening must be informed of the risks and benefits of mammographic screening.

Checklist

- Individual risk of developing cancer assessed and familial cancer service referral considered
- Asymptomatic women aged 50–74 years encouraged to participate in the BreastScreen Australia program
- Recent weight changes discussed and patient's weight recorded
- Alcohol intake discussed and recorded and support for reducing alcohol consumption offered if appropriate
- Smoking status discussed and recorded and brief smoking cessation advice offered to smokers
- Physical activity recorded
- Referral to a dietitian, physiotherapist or exercise physiologist considered
- Education on being sun smart considered

Step 2: Presentation, initial investigation and referral

The following signs and symptoms should be investigated:

- a persistent new lump or lumpiness, especially involving only one breast
- a change in the size or shape of a breast
- a change to a nipple, such as crusting, ulceration, redness or inversion
- a nipple discharge that occurs without manual expression
- a change in the skin of a breast, such as redness, thickening or dimpling
- axillary mass(es)
- an unusual breast pain that does not go away.

Checklist

- Signs and symptoms recorded
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient notified of support services such as Cancer Council 13 11 20

Step 2: Presentation, initial investigations and referral continued

Initial investigations include a triple test of the three diagnostic components:

- medical history and clinical breast examination
- imaging – mammography and/or ultrasound
- non-excision biopsy – preferably a core biopsy.

Referral options

At the referral stage, the patient's GP or other referring doctor should advise the patient about their options for referral, waiting periods, expertise, if there are likely to be out-of-pocket costs and the range of services available. This will enable patients to make an informed choice of specialist and health service.

Communication

The GP's responsibilities include:

- explaining to the patient and/or carer who they are being referred to and why
- supporting the patient and/or carer while waiting for specialist appointments
- informing the patient and/or carer that they can contact Cancer Council on 13 11 20.

Checklist

- Referral options discussed with the patient and/or carer including cost implications

Timeframe

A patient with signs and symptoms that may suggest breast cancer should see a GP **within 2 weeks**.

Optimally, tests should be done **within 2 weeks**.

A positive result on any component of the triple test warrants specialist surgical referral. Ideally, the surgeon should see the patient with proven or suspected cancer **within 2 weeks** of diagnosis. If necessary, prior discussion should facilitate referral.

Step 3: Diagnosis, staging and treatment planning

Diagnosis

The following investigations should be undertaken:

- breast imaging tests including bilateral mammography and ultrasound (or MRI in selected cases)
- ultrasound of the axilla (including fine-needle aspiration of nodes if the axillary ultrasound is abnormal)
- breast core biopsy, if not already undertaken, which allows breast cancer receptor profiles (ER, PR, HER2) to be determined.

Staging investigations for distant disease

Staging is appropriate for patients with confirmed locally advanced or nodal disease and for any patient with clinical symptoms or clinical suspicion of metastatic disease.

Germline genetic testing

For detailed information and referral guidelines for breast cancer risk assessment and consideration of genetic testing, read *eviQ's Referral guidelines for breast cancer risk assessment and consideration of genetic testing* <<https://www.eviq.org.au/cancer-genetics/adult/referral-guidelines/1620-referral-guidelines-for-breast-cancer-risk-as>>.

Treatment planning

Ideally, the multidisciplinary team should discuss all newly diagnosed patients

with breast cancer **before** surgery or neoadjuvant chemotherapy.

Refer to a breast cancer nurse **within 7 days** of a definitive diagnosis.

Research and clinical trials

Consider enrolment where available and appropriate. Search for a trial <www.australiancancertrials.gov.au>.

Communication

The lead clinician's¹ responsibilities include:

- discussing a timeframe for diagnosis and treatment options with the patient and/or carer
- explaining the role of the multidisciplinary team in treatment planning and ongoing care
- encouraging discussion about the diagnosis, prognosis, advance care planning and palliative care while clarifying the patient's wishes, needs, beliefs and expectations, and their ability to comprehend the communication
- providing appropriate information and referral to support services as required
- communicating with the patient's GP about the diagnosis, treatment plan and recommendations from multidisciplinary meetings (MDMs).

Checklist

- Diagnosis confirmed
- Referral to a familial cancer service considered
- Performance status and comorbidities measured and recorded
- Patient discussed at an MDM and decisions provided to the patient and/or carer
- Clinical trial enrolment considered
- Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- Patient referred to support services (such as Cancer Council) as required
- Treatment costs discussed with the patient and/or carer

Timeframe

Diagnostic investigations should be completed **within 2 weeks** of the initial specialist consultation.

¹ Lead clinician – the clinician who is responsible for managing patient care.

The lead clinician may change over time depending on the stage of the care pathway and where care is being provided.

Step 4: Treatment

The aim of treatment for breast cancer and the types of treatment recommended depend on the type, stage and location of the cancer and the patient's age, health and preferences.

Establish intent of treatment

- Curative
- Anti-cancer therapy to improve quality of life and/or longevity without expectation of cure
- Symptom palliation

Surgery for early breast cancer includes:

- breast-conserving surgery or mastectomy
- sentinel node biopsy +/-/or axillary dissection
- oncoplastic surgery
- reconstruction immediately after a mastectomy or delayed to an appropriate time.

Neoadjuvant therapy, usually

chemotherapy may be appropriate for patients with:

- triple-negative or HER2-positive cancer
- locally advanced or inflammatory breast cancer
- large operable cancers, with the aim of reducing the tumour size.

All patients with:

- invasive cancer should be considered for **systemic therapy**
- hormone receptor-positive cancer should be considered for **endocrine therapy**.

Adjuvant bisphosphonates improve survival and should be considered for selected patients being treated for breast cancer with curative intent.

Radiation therapy may be beneficial for:

- patients with early breast cancer after breast-conserving surgery
- selected patients after a mastectomy.

Partial breast irradiation can be considered for selected patients with early breast cancer.

Communication

The lead clinician and team's responsibilities include:

- discussing treatment options with the patient and/or carer including the intent of treatment as well as risks and benefits
- discussing advance care planning with the patient and/or carer where appropriate
- communicating the treatment plan to the patient's GP
- helping patients to find appropriate support for exercise programs where appropriate to improve treatment outcomes.

Checklist

- Intent of treatment established
- Patient made aware that reconstructive surgery can be immediate or delayed
- Risks and benefits of treatments discussed with the patient and/or carer
- Treatment plan discussed with the patient and/or carer
- Treatment plan provided to the patient's GP
- Treating specialist has adequate qualifications, experience and expertise
- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Advance care planning discussed with the patient and/or carer

Timeframe

Surgery should ideally occur within **5 weeks** of the decision to treat (for invasive breast cancer) or **4–6 weeks** after neoadjuvant systemic treatments are complete.

Neoadjuvant chemotherapy should begin **within 4 weeks** of the decision to treat.

Adjuvant chemotherapy should begin **within 6 weeks** of surgery.

Adjuvant chemotherapy for triple-negative breast and HER2-positive breast cancer should begin **within 4 weeks** of surgery.

Endocrine therapy should begin **as soon as appropriate** after chemotherapy, radiation therapy and/or surgery is complete (and in some cases will be started during neoadjuvant treatment).

Radiation therapy should begin **3–4 weeks** after chemotherapy, or **within 8 weeks** of surgery, for patients who do not have adjuvant chemotherapy.

Step 5: Care after initial treatment and recovery

Provide a treatment and follow-up summary to the patient, carer and GP outlining:

- the diagnosis, including tests performed and results
- tumour characteristics
- treatment received (types and date)
- current toxicities (severity, management and expected outcomes)
- interventions and treatment plans from other health professionals
- potential long-term and late effects of treatment and care of these
- supportive care services provided
- a follow-up schedule, including tests required and timing

- contact information for key healthcare providers who can offer support for lifestyle modification
- a process for rapid re-entry to medical services for suspected recurrence.

Communication

The lead clinician's responsibilities include:

- explaining the treatment summary and follow-up care plan to the patient and/or carer
- informing the patient and/or carer about secondary prevention and healthy living
- discussing the follow-up care plan with the patient's GP.

Checklist

- Treatment and follow-up summary provided to the patient and/or carer and the patient's GP
- Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- Patient-reported outcome measures recorded

Step 6: Managing recurrent, residual or metastatic disease

Detection

Most locally recurrent or metastatic will be detected via routine follow-up or by the patient presenting with symptoms.

Treatment

Evaluate each patient for whether referral to the original multidisciplinary team is appropriate. Treatment will depend on the location and extent of disease, previous management and the patient's preferences.

Refer to the 5th ESO-ESMO International Consensus Guidelines for Advanced Breast Cancer (ABC 5) <<https://www.esmo.org/guidelines/breast-cancer/consensus-recommendations-advanced-breast-cancer-abc-5>>.

Advance care planning

Advance care planning is important for all patients but especially those with

advanced disease. It allows them to plan for their future health and personal care by thinking about their values and preferences. This can guide future treatment if the patient is unable to speak for themselves.

Survivorship and palliative care

Survivorship and palliative care should be addressed and offered early. Early referral to palliative care can improve quality of life and in some cases survival. Referral should be based on need, not prognosis.

Communication

The lead clinician and team's responsibilities include:

- explaining the treatment intent, likely outcomes and side effects to the patient and/or carer and the patient's GP.

Checklist

- Treatment intent, likely outcomes and side effects explained to the patient and/or carer and the patient's GP
- Supportive care needs assessment completed and recorded and referrals to allied health services actioned as required
- Advance care planning discussed with the patient and/or carer
- Patient referred to palliative care if appropriate
- Routine follow-up visits scheduled

Step 7: End-of-life care

Palliative care

Consider a referral to palliative care. Ensure an advance care directive is in place.

Communication

The lead clinician's responsibilities include:

- being open about the prognosis and discussing palliative care options with the patient and carers if appropriate
- establishing transition plans to ensure the patient's needs and goals are considered in the appropriate environment.

Checklist

- Supportive care needs assessment completed and recorded, and referrals to allied health services actioned as required
- Patient referred to palliative care
- Advance care directive in place

Visit our guides to best cancer care webpage <www.cancercareguides.org.au> for consumer guides. Visit our OCP webpage <www.cancer.org.au/OCP> for the optimal care pathway and instructions on how to import these guides into your GP software.