Ascension

Screening Guidelines: Breast Cancer Survivorship

Surveillance for Breast Cancer Recurrence:

Use the American Society of Clinical Oncology (ASCO) "Choose Wisely" guidelines: https://www.choosingwisely.org/societies/american-society-of-clinical-oncology/

Laboratory tests and imaging:

- Do not offer routine laboratory tests or imaging, except mammography if indicated, for the detection of disease recurrence in the absence of symptoms.

Signs of recurrence:

- Educate and counsel all women about the signs and symptoms of local or regional recurrence.

Evaluation and genetic counseling:

- Assess the patient's cancer family history.
- Offer genetic counseling if potential hereditary risk factors are suspected (e.g., women with a strong family history of cancer [breast, colon, ovarian, endometrial cancer] or age ≤ 60 years with triple-negative breast cancer.

Endocrine treatment impact, symptom management:

- Counsel patients to adhere to adjuvant endocrine (antiestrogen) therapy.

Screening for Second Primary Cancers:

Cancer screening in average-risk patient: Primary care clinicians/ oncologists should

- Screen for other cancers as they would for patients in the general population
- Provide an annual gynecologic assessment for postmenopausal women on selective estrogen receptor modulator therapies.

Management of pathologic nipple discharge:

- When a patient presents with spontaneous, unilateral nipple discharge, especially if bloody, diagnostic imaging studies including a peri areolar ultrasound should be obtained.

Screening for Second Primary Cancers *continued*:

- If a lesion is not found with traditional image modalities, supplemental imaging with breast MRI should be considered, especially in the presence of dense breasts. Galactograms are discouraged due to their limitations (false positive/negatives, no tissue diagnosis).
- If a lesion is identified, a percutaneous biopsy versus nipple exploration/duct excision should be considered.
    - ❖ *When the differential diagnosis suggests a papillary lesion, a single definitive diagnostic procedure is preferred. If a percutaneous biopsy is considered, a large-bore, vacuum assisted biopsy device should be used when possible/available. If this is not available/possible, nipple exploration/duct excision should be considered. (Rationale: spring-loaded biopsy typically yields fragments of a papillary lesion without a clear diagnosis of an intraductal papilloma, necessitating a potentially preventable additional excisional biopsy procedure)*

Clinicians are encouraged to incorporate individual patient values and insurance coverage considerations in shared decision making regarding screening.

Source and background information is available from your Ministry Market Oncology service line leader.
Disease Site Guideline Lead: Douglas Reding, MD, Ascension Wisconsin
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