



Cancer Screening Programmes

CANCER RESEARCH UK



GUIDELINES

for referral of patients

with breast problems

Second edition

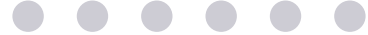
(with amendments)

revised by

Joan Austoker

Robert Mansel





Authors

Dr Joan Austoker
Director
CRC Primary Care Education Research Group
Department of Primary Health Care
University of Oxford
Institute of Health Sciences
Old Road
Headington
Oxford, OX3 7LF

Professor Robert Mansel
Professor of Surgery Head of Department
University Department of Surgery
University of Wales College of Medicine

Professor Michael Baum
Consultant Surgeon
Department of Surgery
Royal Free and University College Medical School

Mr Richard Sainsbury
Consultant Surgeon
Huddersfield Royal Infirmary

Professor Richard Hobbs
Professor of General Practice
University of Birmingham

Published by the NHS Cancer Screening
Programmes on behalf of the Department of Health
Advisory Committee on Breast Cancer Screening

NHS Cancer Screening Programmes
The Manor House
260 Ecclesall Road South
Sheffield S11 9PS

© NHS Cancer Screening Programmes 2003

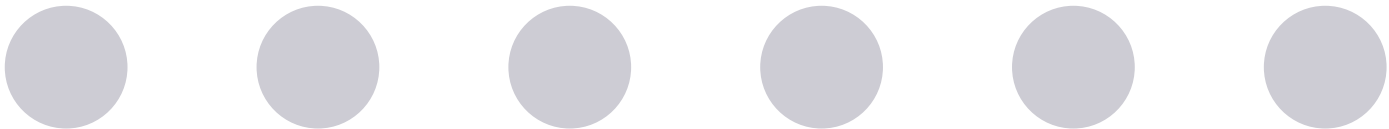
Designed and typeset by
Andrew Haig & Associates

Printed by Longridge Print

ISBN 1-84463-008-0

Further copies can be ordered from
the NHS ReponseLine
Tel: 08701 555 455
Fax: 01623 724 524
Email: doh@prolog.uk.com

A copy is also available in PDF format on
the NHS Cancer Screening Programmes website
www.cancerscreening.nhs.uk



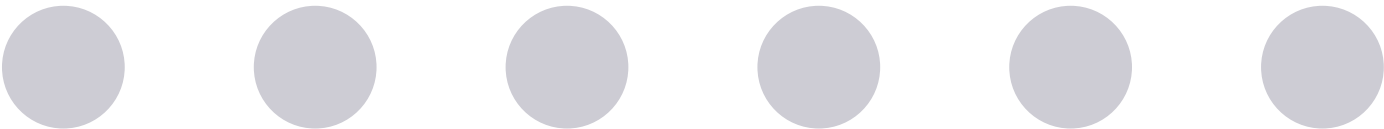


INTRODUCTION

Breast cancer is the commonest malignant condition to affect women, with a 1:11 lifetime risk of developing the disease.

A woman presenting with breast problems is a common occurrence in general practice. General practitioners can expect to see up to 30 new presentations per 1000 women per year, with problems ranging from mild breast pain to frank malignancy.

Over a decade ago, 11–12% of breast referrals proved to be carcinoma (1). Recent surveys have demonstrated a detected carcinoma rate for symptomatic referrals of 6.3% and 5.9% (2, 3). The 50% fall in detection rate is likely to be as a result of an increased awareness of breast disease in the population due to a combination of education, breast screening and media coverage. This has led to an increased presentation of all breast symptoms to the GP and a corresponding increase in referrals, placing pressure on specialist breast clinics.






The purpose of these breast referral guidelines is to make referral an easier, more effective and efficient process, thus improving the ultimate outcome of the care of patients. The first edition of the guidelines was published in December 1995. Since that date over 100,000 copies of the guidelines have been requested, both by individual GPs or practices, and by local authorities and trusts for education and training programmes for local GPs. Feedback from these sources has been taken into account in producing a new edition of the guidelines. We have conducted a systematic literature search for the past four years. There is no new evidence to suggest any changes to the specific guidelines themselves. However, there is an important addition to the guidelines. We have included the new “urgent” category introduced by the Government. We have also included the results of two studies examining the utility of these specific guidelines on referral practice.

It is the GP who decides whether a patient needs to be seen urgently and initiates a specialist outpatient appointment. These referral guidelines have been updated to clarify when a patient’s symptoms are highly suggestive of breast cancer (see page 8). They should form the basis of local agreement between GPs and the specialist breast teams on the criteria to be used. Symptoms should be fully described in the referral request.

GPs are encouraged to do this using same-day direct booking systems, such as electronic media, telephone or fax. Which ever method is used locally, it is essential that the hospital is able to identify immediately those patients being urgently referred.

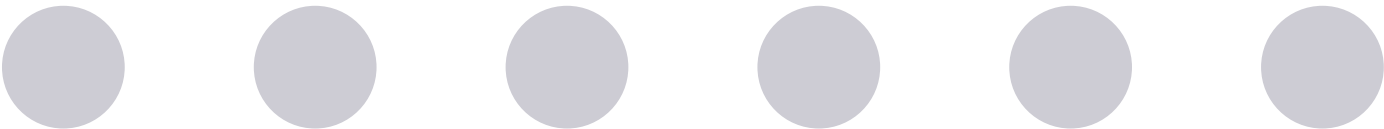
It is important that you should only use the classification “urgent” for those patients whose symptoms are highly suggestive of breast cancer. The main features of the group will be the presence of a discrete lump (see the figure on page 4) in the appropriate age group (see the age incidence figure on page 11). If there are definite signs of cancer such as ulceration, skin nodules or skin distortion then the “urgent” classification applies. Other presentations of breast cancer are much less common, eg nipple discharge or pain in the absence of a lump.





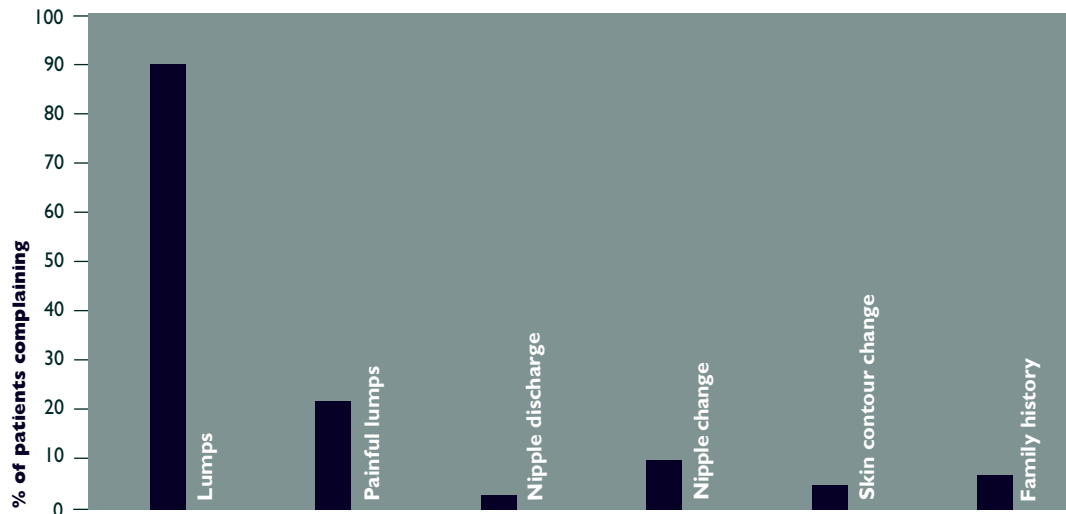
In the first edition of the guidelines we did not include referral guidelines on family history as there was no consensus in this area. This is still the case. As a result, we are still unable to provide specific referral guidelines on family history. However, we have received a large number of requests from GPs to include some guidance on this topic. We have therefore outlined in general terms the factors which are known to influence the chances of a woman being at a significantly increased risk of developing breast cancer at an early age. If you are uncertain whether to refer a woman or not, you should contact your local breast clinic or genetics service for advice. In some areas, local family history referral guidelines have been produced. In general, referral is being recommended when the relative risk of breast cancer is at least three times that of the general population. These women will also generally be at sufficient risk to allow entry into current trials of breast cancer prevention. Women at lower risk should be reassured by their GPs that their risk does not differ greatly from that of the general population.

The first of the two studies which assessed the use of the guidelines was a retrospective survey of the fit of the guidelines in a random sample of GP referrals in South Wales in the 8 months prior to the publication of the guidelines in 1995 (2). Of 2,332 new patients attending the breast clinic, 29% of patients with benign breast disease would not have been referred if the guidelines had been strictly followed. Of the 147 symptomatic carcinomas diagnosed from the GP referrals, no invasive cancers would have been missed. The symptoms and signs reported by the GP in the referred patients with carcinoma were lumps 90%, painful lumps 21%, nipple discharge 3.4%, nipple change 10.2%, skin contour change 4.8% and any family history 6.1% (see the figure on page 4). Referral for pain without a discrete lump constituted 63% of the patients with a benign diagnosis who fell outside the guidelines. Overall, mastalgia without a discrete mass forms approximately 50% of the overall symptoms presenting at both the general practitioners (4) and the surgical outpatients (5). Yet pain alone accounted for only 1 carcinoma referral in this retrospective survey.



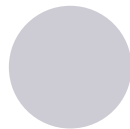
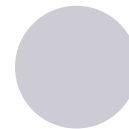
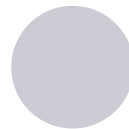
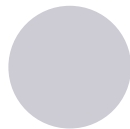



GP reports of symptoms/signs: malignant lesions



The second study was an evaluation of an education programme aimed at training GPs to incorporate the breast referral guidelines into their own practice (6). 83% of the local GP practices in East Surrey were visited individually by a project worker who introduced the guidelines to the GPs. An assessment was made of every new patient attending the local specialist breast clinics in the three months prior to the practice visits and the three months after the practice visits. After the

practice visits, there was a reduction of 28% in the total number of referrals. The number of inappropriate referrals (as assessed against the guidelines) dropped by 70%. This was a highly significant reduction in the proportion of inappropriate referrals over the period of the programme. Inappropriate referrals mentioning breast pain dropped by 73%. There was no significant change in the number of cancers presenting to the clinics in each of the three-month





periods. This study demonstrated the importance of an education programme in significantly increasing GPs' ability to manage breast referrals appropriately.

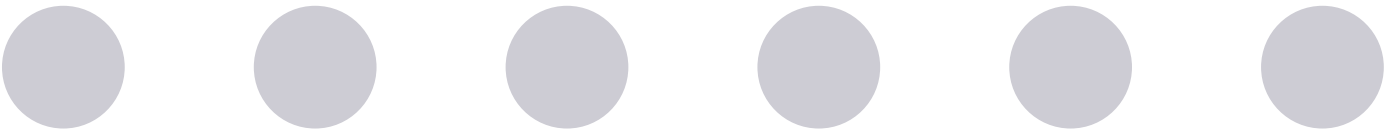
Several studies are currently in progress which may in the future lead to changes in these guidelines. We will also continue to monitor the use of these guidelines in primary care and welcome any feedback from those using the guidelines or those running training sessions.

Dr Joan Austoker
Professor Robert Mansel

February 1999

We would like to thank the Cancer Research Campaign and the NHS Breast Screening Programme for providing support for the development and production of these guidelines.

References

1. Barclay M. *et al.* Patterns of presentation of breast disease over ten years in a specialised clinic. *Health Bull* 1991; **49**: 229-36.
 2. Cochrane R.A. *et al.* Evaluation of general practitioner referrals to a specialist breast clinic according to the UK national guidelines. *Eur J Surg Oncology* 1997; **23**: 198-201.
 3. Gui G.P. *et al.* Clinical audit of a specialist symptomatic breast clinic. *J Roy Soc Med* 1995; **88**: 330-3.
 4. Roberts M.M. *et al.* Consultations for breast disease in general practice and hospital referral patterns. *Br J Surg* 1987; **74**: 1020-2.
 5. Nichols S. *et al.* Management of female breast disease by Southampton general practitioners. *Br Med J* 1980; **281**: 1450-3.
 6. Henderson G. The East Surrey breast cancer referral guidelines project. *Pulse* November 1998.
- 



PREFACE TO THE FIRST EDITION

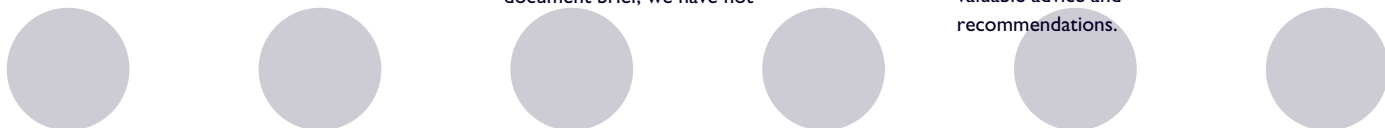
The purpose of these guidelines is to provide general practitioners with advice on which patients with breast problems warrant consideration for referral and which patients can be safely dealt with by the general practitioner. The production of these guidelines was commissioned by the Advisory Committee on Breast Cancer Screening because the existence of the screening programme has led to an increased awareness of breast cancer among women. There is evidence that this has resulted in a greatly increased pressure being placed on general practitioners to provide advice to women about breast problems.


There has been a proliferation of clinical practice guidelines aimed primarily at the clinicians involved in patient care. For this reason, it is important that guideline development follows a specified protocol. At the recommendation of the Royal College of General Practitioners, we used, as far as was possible, the 'Guideline Assessment Tool' that has been drawn up by the Department of Public Health Medicine, University of Hull. We are grateful to Dr Paul Sutton for his help and advice. There is a dearth of literature on the management of breast problems in primary care. For this reason we had to modify how we used the 'Guideline Assessment Tool'.

Initially we undertook a literature review. Very few papers, published or unpublished, dealt specifically with the referral and management of breast disorders in primary care. In order to keep this document brief, we have not

included the list of references. A full list of references can be obtained from the authors.

A preliminary draft of the guidelines was drawn up by a small group chaired by Professor Mansel and including breast surgeons and a GP. Dr Joan Austoker was a member of the working group. We are grateful to Mr Paul Preece, Mr Dudley Sinnett and Dr Eleanor Clarke for their contribution. The draft guidelines were modified by Dr Joan Austoker, Professor Michael Baum and Mr Richard Sainsbury, taking into account the findings of the literature review. The revised draft was circulated to a number of breast surgeons for their comments. Revisions were made in the light of these comments and the guidelines were redistributed to some of the breast surgeons to ensure their satisfaction with the amendments. We are grateful to all the breast surgeons who provided us with valuable advice and recommendations.





Professor Richard Hobbs and Dr Joan Austoker then sent the guidelines to over one hundred general practitioners to seek their views, both on the content and format of the guidelines.

Important changes were made to the guidelines in the light of the views of the general practitioners, and a second mailing to the participating general practitioners ensured that the modifications had addressed their concerns. We would like to thank all these general practitioners, many of whom gave considerable time to considering the guidelines and provided us with detailed comments to aid us in the revision.

The resultant guidelines are not intended to be a definitive statement on how breast disorders should be managed in primary care. They are intended to aid discussions at a local level when drawing up locally produced guidelines. It is essential that general practitioners are involved in this process.

The guidelines set out protocols for the referral and management of breast lumps, breast pain and nipple discharge. We have not included referral guidelines on family history as there is not consensus in this area. Over the next few years we plan to work with the UK Family Cancer Study Group and GPs to draw up guidelines for primary care on the management of women with a family history of breast cancer. We hope to include these in the next edition of these guidelines. In the meantime, we suggest that local protocols are drawn up to assist general practitioners in their management of women with a family history of breast cancer.

Guidelines should not be static, but continually evolving in the light of research and clinical practice. Also, writing guidelines is easier than making them work. Over the next few years we shall be assessing the use of these guidelines in primary care in two randomised controlled trials. These studies will consider

how well these guidelines work in primary care, providing us with some insight into the skills required for the diagnosis, management and referral of breast disorders in primary care. The studies will also consider the time and training implications. We also hope to collect all examples of locally produced guidelines plus any evidence of how these have worked in primary care. Based on this experience, we will then produce a new edition of the guidelines. In the meantime we hope that the present guidelines provide a useful starting point for considering the referral and management of breast disorders in primary care.

December 1995





URGENT REFERRALS

If you suspect that your patient has breast cancer you should make an urgent referral. GPs are encouraged to do this using same-day direct booking systems such as electronic media, telephone or fax.

It is important that you should only use the classification "urgent" for those patients whose symptoms are highly suggestive of breast cancer. The main features of this group will be:

- A discrete lump (see figure on page 4) in the appropriate age group (see figure on page 11)
- Definite signs of cancer such as:
 - ulceration
 - skin nodule
 - skin distortion

Other presentations of breast cancer are much less common eg nipple discharge or pain in the absence of a lump.



Conditions that require

referral to a surgeon

with a special interest

in breast disease

Lump

- Any new discrete lump
- New lump in pre-existing nodularity
- Asymmetrical nodularity that persists at review after menstruation
- Abscess
- Cyst persistently refilling or recurrent cyst

Pain

- If associated with a lump
 - Intractable pain not responding to reassurance, simple measures such as wearing a well-supporting bra, and common drugs
- Unilateral persistent pain in post-menopausal women

Nipple discharge

- Women under 50 with:
bilateral discharge sufficient to stain clothes
bloodstained discharge
persistent single duct discharge
- All women aged 50 and over

Nipple retraction or distortion, nipple eczema

Change in skin contour

Family history

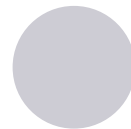
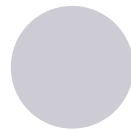
Request for assessment by a woman with a strong family history of breast cancer (see page 20)

SUMMARY

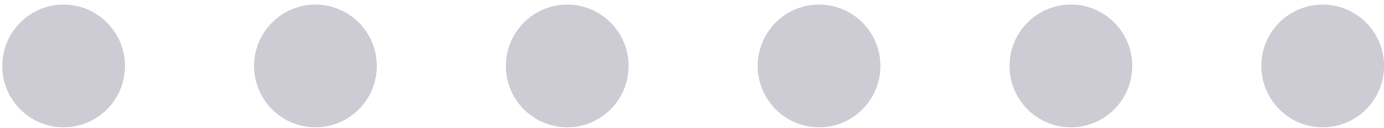
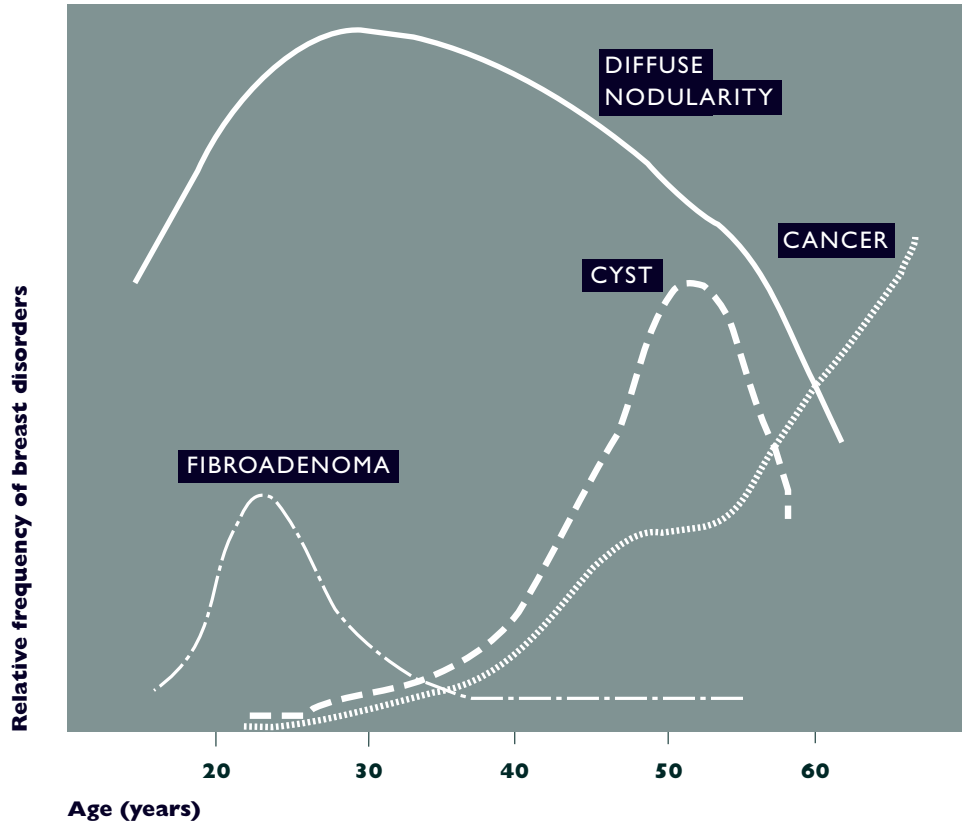


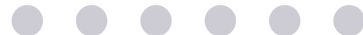
Women who can be managed, at least initially, by their general practitioner

- Young women with tender, lumpy breasts and older women with symmetrical nodularity, provided that they have no localised abnormality.
- Women with minor and moderate degrees of breast pain who do not have a discrete palpable lesion.
- Women aged under 50 who have nipple discharge that is from more than one duct or is intermittent and is neither bloodstained nor troublesome.
- Asymptomatic women with minor family histories at low risk of developing breast cancer.

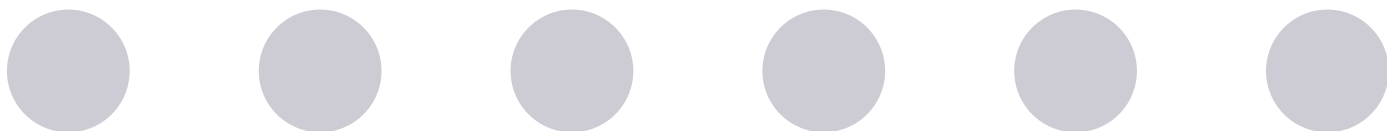
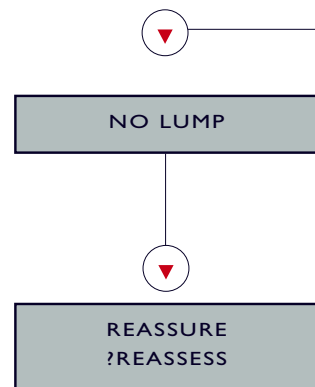


**Incidence of
breast cancer
and benign
conditions
against age**





URGENT REFERRALS
See page 8



BREAST LUMP

HISTORY



EXAMINE

DISCRETE LUMP

REFER

DOMINANT ASYMMETRICAL
NODULARITY

<35 YEARS WITH
STRONG POSITIVE
FAMILY HISTORY
OR
≥35 YEARS

REFER

<35 YEARS WITHOUT
FAMILY HISTORY

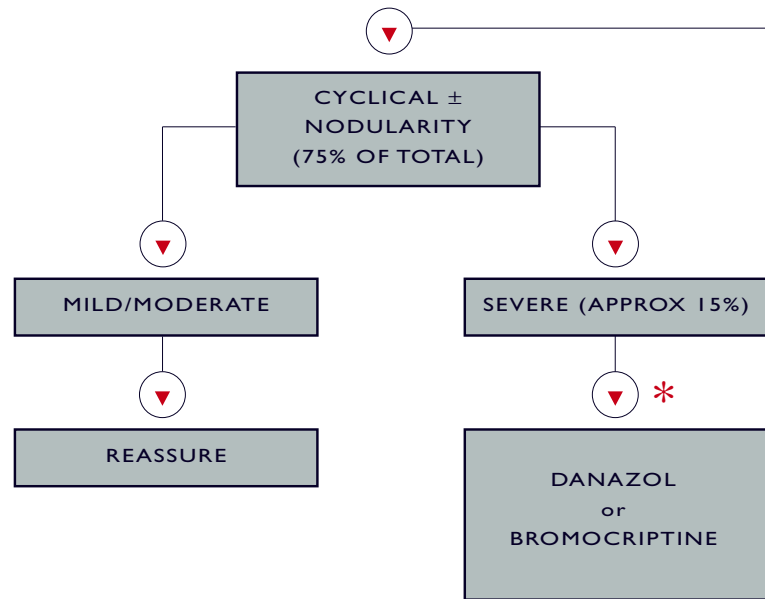
REVIEW ⁶/₅₂

NODULARITY GONE:
REASSURE

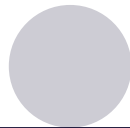
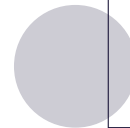
REFER IF PERSISTENT



URGENT REFERRALS
See page 8



* Local management protocols may differ. Please discuss with your local breast unit.



BREAST PAIN

HISTORY



EXAMINE TO EXCLUDE
DISCRETE MASS



DISTINGUISH CYCLICAL
FROM NON-CYCLICAL
– USE PAIN CHART



NON-CYCLICAL (25% OF TOTAL)



MILD/MODERATE



REASSURE



SEVERE (APPROX 50%)



DIFFUSE



LOCAL



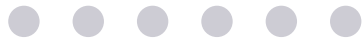
REFER



DANAZOL OR
BROMOCRIPTINE



IF PERSISTENT OR REFRACTORY TO TREATMENT THEN REFER





SEVERE MASTALGIA



Examine and reassure
Assess with breast pain chart

Protocol for treating

severe cyclical mastalgia

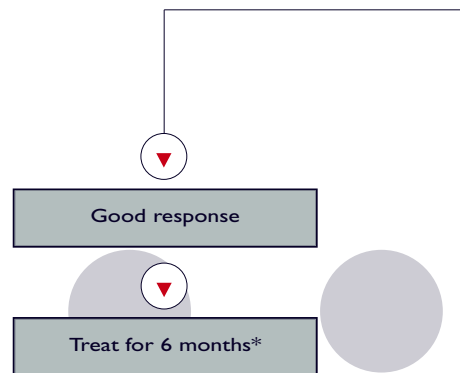
(mild/moderate mastalgia

requires examination

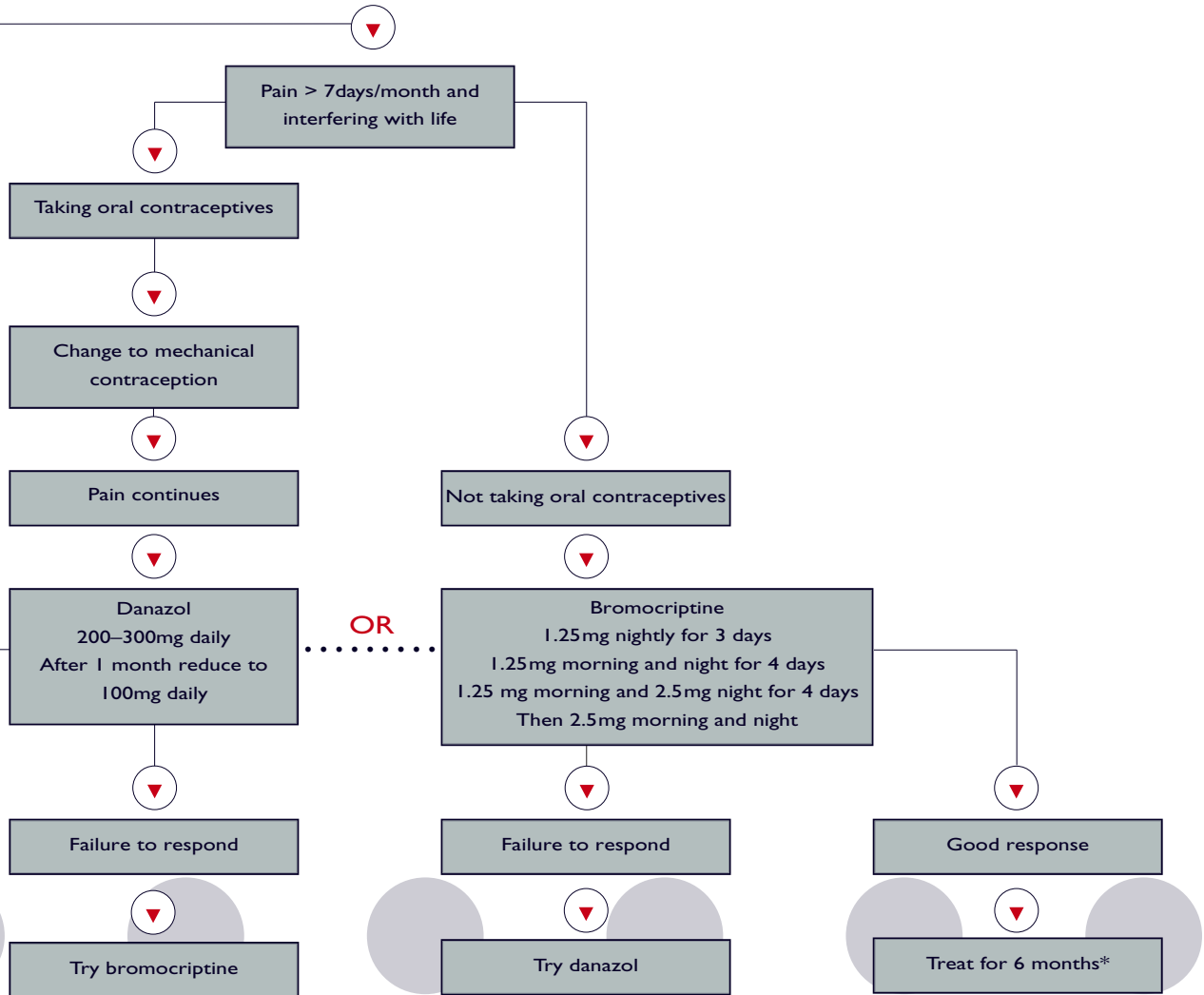
and reassurance)

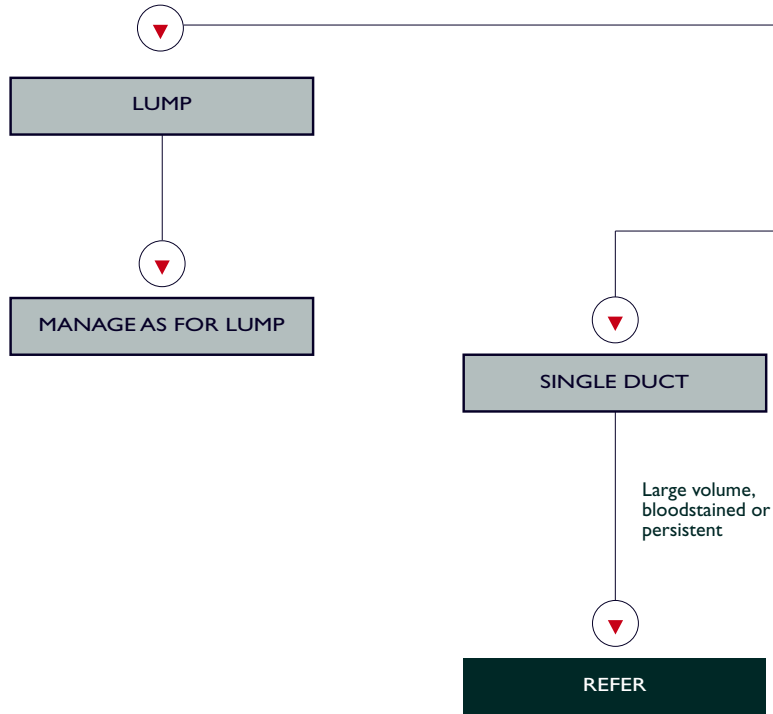
The Medicines Control Agency (MCA) – predecessor to the Medicines and Healthcare products Regulatory Agency (MHRA) – made the decision to withdraw the Marketing Authorisations for products containing gamolenic acid following a review by the Committee on Safety of Medicines (CSM) and the Medicines Commission. The CSM and Medicines Commission came to the conclusion that the data did not support the current standard of effectiveness required for authorisation of these products as medicines for the treatment of breast pain and eczema.

* After 6 months treatment should be stopped. In only half of patients will breast pain recur, and some of these will not need further treatment because pain is milder. Severe recurrences can be treated with further course of previously successful treatment.

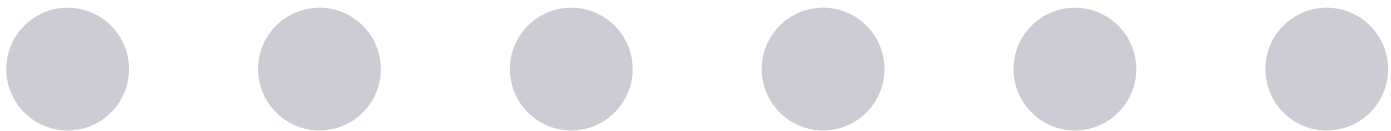


SEVERE CYCLICAL MASTALGIA





URGENT REFERRALS
See page 8



NIPPLE DISCHARGE

HISTORY



EXAMINE

NO LUMP

<50 YEARS

≥50 YEARS

MULTIPLE DUCTS

BLOODSTAINED OR
SEROUS

COLOURED OR
CLEAR DISCHARGE

REFER

TEST FOR BLOOD

CHECK MEDICATION

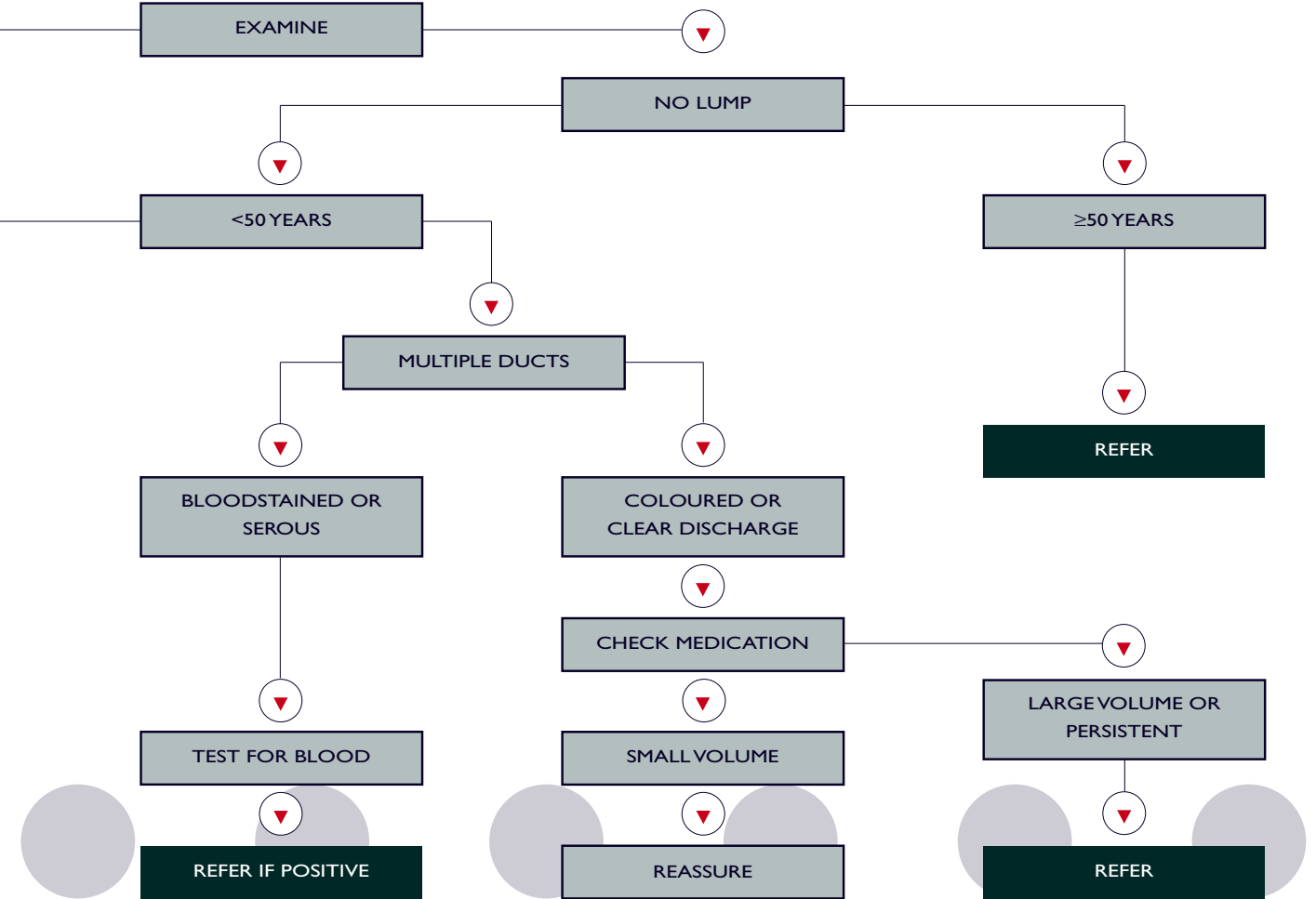
LARGE VOLUME OR
PERSISTENT

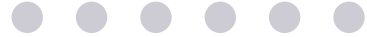
REFER IF POSITIVE

SMALL VOLUME

REASSURE

REFER





FAMILY HISTORY

Consensus does not yet exist in this area. Local guidelines for referral (if they exist) vary. It is known that having a close relative with breast cancer may increase a woman's lifetime risk of developing breast cancer. However, simply having one relative with breast cancer does not mean a woman is necessarily at risk of having inherited a cancer predisposing gene. Her risk may only be a little higher than that of the average woman in the community. There is evidence that the risk is increased if:

- Several relatives on the same side of the family have been affected, especially with a young age of onset (under 50)
- There is a case of bilateral breast cancer in a close family member
- There is a case of male breast cancer in a close family member
- There are cases of both breast and ovarian cancer in close relatives on the same side of the family.

If you are uncertain whether to refer a woman or not, contact your local breast clinic or genetics service for advice. Women at low risk should be reassured that their risk does not differ greatly from that of the general population. They should receive advice on breast awareness and be advised to report any symptoms or changes to their family history promptly.

References

Goldgar D.E., Stratton M.R., Eeles R.A. Familial breast cancer. In Eeles R.A. *et al.* (eds). *Genetic Predisposition to Cancer*. Chapman and Hall Medical, 1996, 227-238.

Pharoah P.D.P., Day N.E., Duffy S., Easton D.F., Ponder B.A.J. Family history and the risk of breast cancer: a systematic review and meta-analysis. *Int J Cancer* 1997; **71**: 800-809.





Investigation

of symptoms in

referred patients*

Breast lump

Triple assessment:

clinical examination

imaging (mammography and/or ultrasound)

fine needle aspiration cytology (\pm core biopsy)

Cyst: assessed by ultrasound prior to aspiration

Breast pain

Unilateral persistent mastalgia:

mammography

or

ultrasonography

Localised areas of painful nodularity:

mammography

or

ultrasonography

Focal lesions:

fine needle aspiration cytology

Nipple discharge

Clinical examination

Mammography

Nipple retraction

Clinical examination

Mammography

Change in skin contour

Clinical examination

Mammography

Ultrasound



* These are the investigations carried out by the specialist



Cancer Screening Programmes

CANCER RESEARCH UK

