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Chemoprevention for women with no personal history of breast cancer

1) Patient cohort

NICE guidelines June 2013[1] recommended "discussion of the absolute risks and benefits of all options for chemoprevention to women at high (>30%) or moderate (17 – 30%) life time risk of breast cancer".

Chemoprevention should be offered proactively as an option rather than waiting for women to request it

The recommended duration of chemoprevention is 5 years[2-6]

For women aged less than 35 who want to defer risk-reducing mastectomy, chemoprevention may be discussed though there is no evidence base to support this activity[2-6]

2) Process

Proper risk assessment to give statistical calculation for lifetime risk and risk between ages 40 and 50[7], by a suitably trained professional (eg specialist nurse, breast clinician, surgeon) as part of the wider Breast MDT.

Units might consider a separate role for a trained specialist nurse as it involves complex and time-consuming consultations of triaging, risk assessment and counselling about risk-reduction options.

There should be close liaison with the Department of Clinical Genetics. NICE Guidance should be followed as to the calculation of lifetime risk. Breast surgeons and allied professionals are probably best placed to discuss the detail of surgical risk reducing procedures.

3) Information for the patient

A relative risk reduction of 30-50% can be obtained with chemoprevention. Supplement this figure with a calculation as to *absolute* risk reduction. No survival benefit has been shown in randomised trials[2-6].

Tamoxifen[2,3], raloxifene[4,5] or an aromatase inhibitor may be commenced. The side effects should be detailed. A tailor-made chemoprevention patient information leaflet such as that supplied by the Cancer Genetics Group should be provided (http://www.ukcgg.org/information-education/websites-downloads/) [6,8]

4) Prescription and monitoring

A letter should be sent to the general practitioner detailing the consultation, discussion and agreement to proceed with chemoprevention. It should include the drug name and daily dose as well as proposed duration and important and common side effects and how they are best managed. The general practitioner is asked to prescribe the drug. Specific hospital based follow up is not needed in this area.

Bone density measurements for those patients prescribed an aromatase inhibitor should be performed according to that Breast Unit's protocol.

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On behalf of the ABS Council

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Note:
Members of ABS Council and Committees met and discussed a set of topics on which it was felt clinical guidance was sought by ABS members. This document represents the considered, agreed opinions of experienced breast surgeons. It is not meant to supplant

authoritative guidelines. Discussion and correspondence would be gratefully received by the ABS to lucydavies@absgbi.org.uk