

ASCO 2006 Update of the Breast Cancer Follow-Up and Management Guideline in the Adjuvant Setting

Context

The ASCO Expert Panel presents the 2006 evidence-based clinical practice guideline for breast cancer follow-up and management in asymptomatic patients following primary, curative therapy (*J Clin Oncol* 24:5091-5097, 2006). The Panel performed a literature review and analysis of data published through March 2006.

Updated 2006 Recommendations

Table 1 presents a complete summary of the updated 2006 recommendations.

Discussion

As guideline recommendations are based on well-defined study protocols and outcomes, many of the recommendations for the 2006 Update remained unchanged due to inapplicable study findings or no resulting survival advantages. Issues new to the guideline include fluorodeoxyglucose–positron emission tomography scanning and breast magnetic resonance imaging as follow-up strategies. However, a review of the literature revealed no evidence that use of these imaging studies would improve outcomes for asymptomatic women during routine breast cancer surveillance. The 2006 update also includes new recommendations on genetic counseling referrals for familial breast cancer syndromes consistent with recommendations from the US Preventive Services Task Force. The evidence continues to support regular history, physical examination, and mammography as the cornerstones of breast cancer follow-up and management.

Methodology

The Breast Cancer Surveillance Expert Panel did not complete an independent meta-analysis of the data from available randomized clinical trials given the availability of a high-quality meta-analysis and a systematic literature review identified through the literature search. The 2006 Update literature review applied more weight to studies that tested a hypothesis directly relating testing to one of the primary outcomes in randomized design. The Expert Panel utilized the ASCO 1996 list of clinical outcomes used to justify the use of a technology to drug in the guideline development process. Outcomes of interest included disease-free and overall survival, quality of life, toxicity reduction, and cost-effectiveness.

It is important to realize that many management questions have not been comprehensively addressed in randomized trials and guidelines cannot always account for individual variation among patients. A guideline is not intended to supplant physician judgment with respect to particular patients or special clinical situations and cannot be considered inclusive of all proper methods of care or exclusive of other treatments reasonably directed at obtaining the same results.

Accordingly, ASCO considers adherence to this guideline to be voluntary, with ultimate determination regarding its application to be made by the physician in light of each patient's individual circumstances. In addition, the guideline describes administration of therapies in clinical practice; it cannot be assumed to apply to interventions performed in the context of clinical trials, given that clinical studies are designed to test innovative and novel therapies in a disease and setting for which better therapy is needed. Because guideline development involves a review and synthesis of the latest literature, a practice guideline also serves to identify important questions for further research and those settings in which investigational therapy should be considered.

Additional Resources

The full-text version of the guideline recommendations is available in the November 1, 2006, print edition of the *JCO* and also at www.jco.org (*J Clin Oncol* 24:5091-5097, 2006). In addition, a patient guide, summary slide set, patient flow sheet, and an update table are available at <http://www.asco.org/guidelines/breastfollowup>. The patient guide is available at <http://www.plwc.org/patientguides>.

The ASCO 2006 Update of Recommended Breast Cancer Surveillance Guidelines were developed and written by James L. Khatcheressian, Antonio C. Wolff, Thomas J. Smith, Eva Grunfeld, Hyman B. Muss, Victor G. Vogel III, Francine Halberg, Mark R. Somerfield, and Nancy E. Davidson, for the American Society of Clinical Oncology Breast Cancer Surveillance Expert Panel.

Table 1: Summary of Recommendations

Recommended breast cancer surveillance	
History/physical examination	Every 3 to 6 months for the first 3 years after primary therapy; every 6 to 12 months for years 4 and 5; then annually.
Patient education regarding symptoms of recurrence	Physicians should counsel patients about the symptoms of recurrence including new lumps, bone pain, chest pain, abdominal pain, dyspnea or persistent headaches. Helpful Web sites for patient education include www.plwc.org and www.cancer.org .
Referral for genetic counseling	Criteria include: <ul style="list-style-type: none"> ■ Ashkenazi Jewish heritage. ■ History of ovarian cancer at any age in the patient or any first- or second-degree relatives. ■ Any first degree relative with a history of breast cancer diagnosed before age 50 years. ■ Two or more first- or second-degree relatives diagnosed with breast cancer at any age. ■ Patient or relative with diagnosis of bilateral breast cancer. ■ History of breast cancer in a male relative.
Breast self-examination	All women should be counseled to perform monthly breast self-examination.
Mammography	First post-treatment mammogram 1 year after the initial mammogram that leads to diagnosis, but no earlier than 6 months after definitive radiation therapy. Subsequent mammograms should be obtained as indicated for surveillance of abnormalities.
Coordination of care	The risk of breast cancer recurrence continues through 15 years after primary treatment and beyond. Continuity of care for breast cancer patients is encouraged and should be performed by a physician experienced in the surveillance of cancer patients and in breast examination, including the examination of irradiated breasts. If follow-up is transferred to a PCP, the PCP and the patient should be informed of the long-term options regarding adjuvant hormonal therapy for the particular patient. This may necessitate re-referral for oncology assessment at an interval consistent with guidelines for adjuvant hormonal therapy.
Pelvic examination	Regular gynecologic follow-up is recommended for all women. Patients who receive tamoxifen should be advised to report any vaginal bleeding to their physicians.
Not recommended	
Routine blood tests	CBCs and liver function tests are not recommended.
Imaging studies	Chest x-ray, bone scans, liver ultrasound, CT scans, FDG-PET scans, and breast MRI are not recommended.
Tumor markers	CA 15-3, CA 27.29, and CEA are not recommended.

Abbreviations: PCP, primary care physician; CT, computed tomography; FDG-PET, fluorodeoxyglucose–positron emission tomography; MRI, magnetic resonance imaging; CEA, carcinoembryonic antigen.



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