Survivorship – Noninvasive Breast Cancer

Note: Mammograms may continue as long as the patient has a 10-year life expectancy and no co-morbidities that would limit the diagnostic evaluation or treatment of any identified problem.

ELIGIBILITY

Patients with noninvasive breast cancer, from the completion of treatment[1] up to 5 years and no evidence of disease (NED)

CONCURRENT COMPONENTS OF VISIT

SURVEILLANCE

- History and physical with clinical breast exam every 6 months up to 5 years from date of diagnosis, and then annually thereafter
- Imaging recommendations for patients assigned female at birth and transgender women who have breast tissue:
  - Routine imaging of the chest wall or reconstructed breast following mastectomy is not indicated
  - Diagnostic mammography[2] with or without tomosynthesis annually for patients who had breast conservation therapy
  - Consider additional MRI breast with and without contrast as indicated[3,4,5]
- Assess for compliance with endocrine therapy and assess for toxicities if appropriate

Suspected new primary or biopsy-proven recurrence?

- Yes
  - For new primary or recurrence that is biopsy proven to be invasive breast cancer see Breast Cancer – Invasive algorithm
  - For a new primary or recurrence that is non-invasive histology, see Breast Cancer – Ductal Carcinoma in Situ algorithm
    - **Primary Oncologist** to discuss Goal Concordant Care (GCC) with patient, or if clinically indicated, with Patient Representative[6]
- No
  - Continue survivorship monitoring

MONITORING FOR LATE EFFECTS

RISK REDUCTION/ EARLY DETECTION

PSYCHOSOCIAL FUNCTIONING

See Page 2

[1] Completion of all treatment with the exception of endocrine agents

[2] Diagnostic mammography for up to 3 years post diagnosis then screening mammography thereafter

[3] Consider additional MRI breast with and without contrast annually for patients with germline mutations (see Appendix A in the Breast Cancer Screening algorithm for type of mutation and recommended screening interval). Alternating mammography and MRI breast every 6 months is suggested if feasible.

[4] Consider additional MRI breast with and without contrast annually if diagnosis prior to age 50 years and have heterogeneously or extremely dense breasts. Alternating mammography and MRI breast every 6 months is suggested if feasible. This can be considered as delineated in the recommendation from the American College of Radiology (ACR) and the American Cancer Society (ACS). Note that the data supporting these guidelines are outdated (as per our internal analysis) and additional imaging is not recommended by the National Comprehensive Cancer Network (NCCN) survivorship guidelines. This approach is an active area of investigation within MD Anderson.

[5] If there is a contraindication to MRI (*e.g.*, lack of tolerance or access to MRI), may consider bilateral ultrasound breast or contrast-enhanced mammography (CEM)

[6] GCC should be initiated by the **Primary Oncologist**. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to GCC home page (for internal use only).

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Approved by the Executive Committee of the Medical Staff on 03/18/2025

Survivorship – Noninvasive Breast Cancer

Note: Mammograms may continue as long as the patient has a 10-year life expectancy and no co-morbidities that would limit the diagnostic evaluation or treatment of any identified problem.

ELIGIBILITY

Patients with noninvasive breast cancer, from the completion of treatment[1] up to 5 years and no evidence of disease (NED) *(continued from previous page)*

CONCURRENT COMPONENTS OF VISIT

MONITORING FOR LATE EFFECTS

Consider the following based on risk factors:
- Bone health[2] (see Survivorship – Breast Cancer: Bone Health algorithm)
- Sexual health/fertility
- Postmenopausal women receiving tamoxifen should have close monitoring for symptoms of uterine cancer or endometrial hyperplasia
- Physical Therapy for upper extremity range of motion and muscle strength assessment[3]
- Consider Plastic Surgery for discussion of surgical interventions to reduce radiation fibrosis or symptoms of breast lymphedema
- Patient education regarding symptoms including radiation therapy complications if appropriate

RISK REDUCTION/ EARLY DETECTION

Patient education, counseling, and screening:
- Lifestyle risk assessment[4]
- Cancer screening[5]
- Screening for Hepatitis B and C as clinically indicated (see Hepatitis B Virus (HBV) Screening and Management and Hepatitis C Virus (HCV) Screening algorithms)
- Consider cardiovascular risk reduction (see Survivorship – Adult Cardiovascular Screening algorithm)
- Genetic screening (if not already done) (see Genetic Counseling algorithm, NCCN, and USPSTF guidelines)
- Vaccinations[6] as appropriate
  - HPV vaccination as clinically indicated (see HPV Vaccination algorithm)

PSYCHOSOCIAL FUNCTIONING

Assess for:
- Distress management (see Distress Screening and Psychosocial Management algorithm)
- Body image
- Financial stressors
- Social support

DISPOSITION

Refer or consult as indicated

USPSTF = United States Preventive Services Task Force

[1] Completion of all treatment with the exception of endocrine agents
[2] All postmenopausal women (especially those on aromatase inhibitors)
[3] Consider Physical Medicine and Rehabilitation consultation for patients who have restricted range of motion unrelieved by physical therapy to discuss additional strategies for improved physical functioning
[4] See Physical Activity, Nutrition, Obesity Screening and Management, and Tobacco Cessation algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice
[5] Includes cervical, colorectal, liver, lung, pancreatic, prostate, and skin cancer screening
[6] Based on American Society of Clinical Oncology (ASCO) guidelines

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