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Positive Quality Intervention: Overview of Breast Cancer Survivorship

Description: This PQI will provide guidance on breast cancer survivorship care for adult women.[1]

Background: An individual is considered a cancer survivor from the time of cancer diagnosis through the balance of the individual's life. It includes those who are starting, currently ongoing, and completed their treatment or are in clinical remission.[2] The average 5- and 10-year survival rates for women with non-metastatic invasive breast cancer are 90% and 84% respectively. The 5-year survival rate for women with metastatic breast cancer is 28%.[3] To optimize healthcare outcomes for breast cancer patients, it is pivotal to ensure they obtain proper surveillance, follow-up care, health promotion, and efficient management of new, recurrent, or late effects from cancer treatment.[1] One landmark publication by the Institute of Medicine discussed essential components of survivorship care. These included prevention of new/recurrent cancers and other late effects, surveillance of cancer spread/recurrence, intervention for consequences of cancer/cancer treatment, and coordination between specialists and primary care providers to ensure all health needs of the survivor are met.[3] Another landmark publication by the Institute of Medicine discussed various actions to take that ensure that the psychosocial health needs of patients are addressed.[4] A LIVESTRONG survey for individuals affected by cancer demonstrated that post treatment cancer survivors who received a treatment summary containing information about treatment exposures more often reported that their needs had been met, including receiving information about possible late effects, care they received during treatment, and care they received after treatment.[5] Many of the recommendations in this PQI are derived from the American Cancer Society/American Society of Clinical Oncology Breast Cancer Survivorship Care Guideline. Those recommendations are from a limited evidence base with a few randomized controlled trials and, for this reason, they should be considered as possible management strategies.[1] Additionally, ethnic and racial minority groups, among other groups, may be exposed to various factors (ex. stress, low socioeconomic status, lack of access to care/healthy food/health insurance, etc.) which lead to various health disparities and a disproportionate amount of comorbidities; ultimately affecting how these recommendations can be utilized.[6]

PQI Process:[1] The recommendations shown below should be utilized by primary care clinicians caring for adult female breast cancer survivors:

- Individualize clinical follow-up care based on age, specific diagnosis, treatment protocol, and as recommended by the oncology team
- Maintain communication with the oncology team throughout the patient's diagnosis, treatment, and post-treatment care
- Encourage the inclusion of caregivers, spouses, or partners in usual breast cancer survivorship care and support
- The following abbreviated terms are used in the table below:

SERMs	Selective estrogen receptor modulator therapies
SSRIs	Selective serotonin reuptake inhibitors
SNRIs	Serotonin and norepinephrine reuptake inhibitors
NSAIDs	Non-steroidal anti-inflammatory drugs
PROMIS®	Patient-Reported Outcomes Measurement Information System®
CVD	Cardiovascular disease

Surveillance for breast cancer recurrence	
Conduct a detailed and individualized history & physical	• Every 3-6 months for the first 3 years after primary therapy, 6-12 months for the next 2 years, and annually thereafter.[1]
Assess for signs of recurrence and screening for local recurrence/new primary breast cancer	• Educate and counsel on these signs and symptoms (ex. new lumps/swelling, rash or skin changes on the breast).[1] • Refer for annual mammography: the intact breast if patient received unilateral mastectomy or both breasts if patient received lumpectomy.[1]
Assess patient's cancer family history	• Offer genetic counseling/testing if there are hereditary risk factors.[1] • Counsel patients to adhere to adjuvant endocrine (antiestrogen) therapy.[1] • Update personal & family history on a regular basis.
Screening for second primary cancers	
Conduct cancer screenings in the average risk patient	• As you would for patients in the general population.[1] • Annual gynecological assessment for post-menopausal women on SERMs.[1]
Assessment and management of physical and psychosocial long-term and late effects of breast cancer and treatment:	
Conduct psychosocial assessments and offer counseling, pharmacotherapy, or appropriate referral	• Body image/appearance concerns and refer for psycho-social care as indicated.[1] • Distress, depression, anxiety (especially if: young, history of prior psychiatric disease, and low socioeconomic status), and fear of cancer recurrence [1,2] • Fatigue and its causative factors.[1,2] • Cognitive impairment and its reversible contributing factors.[1,2] • As necessary, use the NCCN distress thermometer, PHQ-9 for depression, GAD-7 for anxiety, PC-PTSD-5 for trauma, or PROMIS® measures.[1,2]
Assess lymphedema risk early on & refer to an appropriate therapist when risks are present	• Clinical symptoms: swelling on same side of cancer treatment, decreased range of motion, fullness, tightness, heaviness, or pain.[2] • Risks: radiation to the axillary, supraclavicular, cervical, or inguinal lymph node systems, sentinel node biopsy, obesity, localized infection, increased number of nodes removed, and higher initial extent of disease.[2]
Make cardiovascular considerations	• Pre-existing/emerging CVD and risk factors, cancer treatment history, and diet/exercise habits.[1,2] • Manage obesity, diabetes, hypertension, hyperlipidemia, tobacco use, and other CVD risk factors. [1,2] • Monitor blood pressure, blood glucose, lipid levels, etc.[1,2]
Assess Bone/musculoskeletal health	• Current bone loss/metastases: avoid exercises that place high load on fragile skeletal sites, minimize fall risk, and refer if bone pain develops.[2] • Post-menopausal breast cancer survivors: baseline DEXA scans.[1] • Repeat DEXA scans biennially: women on an aromatase inhibitor, tamoxifen, GnRH agonist, and have chemotherapy-induced, premature menopause).[1]
Assess pain & neuropathy	• Pain: use a simple pain scale, obtain comprehensive history, offer interventions (ex. acetaminophen, NSAIDs, physical activity, and/or acupuncture), and refer to an appropriate specialist when needed.[1] • Neuropathy: physical activity and duloxetine for appropriate patients with neuropathic pain, numbness, and tingling.[1]
Assess sexual health/fertility early (especially childbearing age survivors)	• Genitourinary syndrome: Vaginal dryness or atrophy: offer nonhormonal, water-based lubricants and moisturizers or consider use of vaginal estrogen in low-risk women with symptoms not managed by over-the-counter options.[1,10] • Refer to psychoeducational support, group therapy, sexual counseling, marital counseling, or intensive psychotherapy when appropriate.[1]
Assess for premature menopause/hot flashes	• SNRIs, SSRIs, gabapentin, lifestyle, and/or environmental modifications.[1]

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Patient Centered Activities:

- **Information needs of patients:**
  - ACS Survivorship Center website, the ACS website, Journey Forward, ASCO survivor and caregiver site, and the NCCN patient and caregiver resources[1,7]
- **Physical Activity**
  - Avoid sedentary lifestyles by walking, taking the stairs, etc
  - Strive for ≥150 minutes of weekly activity (goal: ≥300 minutes of moderate intensity exercises)
  - 2-3 sessions per week of strength and resistance training of major muscle group with stretching 2 days per week
  - Reduce risk of cardiovascular complications
  - Weight loss may help with lymph edema
- **Diet:**
  - High in vegetables, fruits, whole grains, and legumes
  - Low in saturated fats and alcohol consumption, processed foods, refined sugars
  - < 18 oz per week of red meat consumption
  - Weight loss may help with risk of recurrence, lymphedema (obesity is a risk factor), and medical weight management should be considered if behavioral interventions have limited success.
- **Tobacco Cessation:**
  - Avoid tobacco and refer survivors who do to cessation counseling and resources.
  - Engage in Behavior therapy
  - Pharmacotherapy (when necessary): Nicotine replacement therapy (NRT) with the nicotine patch and a short acting NRT (gum, lozenge, inhaler, nasal spray)[9]
- **Psychosocial Considerations:**
  - Interventions (including couples based) to promote coping skills and provide specific techniques to address body image issues and issues related to intimacy[1,8]
  - Cognitive based therapy, physical activity, or correcting anemia, thyroid dysfunction, cardiac function, mood disorders, sleep disturbance, and pain may improve fatigue

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