



# FOLLOW-UP GUIDELINES

## Breast Cancer

March 2012

*Clinical practice guidelines have been developed after multi-disciplinary consensus based on best available literature. As the name suggests, these are to be used as a guide only. These guidelines do not replace Physician judgment which is based on multiple factors including, but not limited to, the clinical and social scenario, comorbidities, performance status, age, available resources and funding considerations.*

*Participating in clinical trials is encouraged when available.*

### Follow-Up for All Patients

1. **Recommended follow-up:** There is no evidence from randomized trials supporting any particular follow up sequence or protocol. We would recommend.
  - a) Physical examination every six months for the first five years and then annually. Examination should include the affected breast or mastectomy site, chest wall, regional lymph node areas (axillary and supraclavicular), contralateral breast, auscultation of the chest, palpation of the liver and a check for spinal tenderness.
  - b) Annual bilateral mammogram, or in the case of unilateral mastectomy, annual mammogram of the contralateral breast.
  - c) If women wish to carry out breast self-exams, it is reasonable to educate regarding the proper procedures.
  - d) For any patient with a history of breast cancer, the use of hormone replacement therapy should be reviewed with their health care provider as it is relatively contraindicated.
  - e) In the absence of clinical signs or positive physical findings, blood work including tumor marker, chest x-rays, bone scans or other special investigations are not recommended.
  - f) **Contraception:** If permanent contraception is desired by the patient and her husband, then tubal ligation should be considered. For patients who are not yet ready to contemplate sterilization, a non-hormonal procedure such as barrier techniques or an IUD should be recommended.
  - g) **Side effects of Hormonal therapy:** Women treated with AI is recommended to receive Vitamin D and calcium as nutritional supplements. A dual energy X-ray absorption scan (DEXA) is recommended to allow early treatment of osteoporosis. Women experiencing premature menopause due to chemotherapy or ovarian suppression should also have DEXA scan. Bisphosphonates prevents bone loss in patients with iatrogenic premature menopause and in post-menopausal patients treated with AIs. Vasomotor symptoms should be managed without hormonal therapy; Venlafaxine, gabapentin and clonidine are used with limited success. SSRI's beside venlafaxine should be avoided in patients on tamoxifen as these drugs are CYP2D6 inhibitors. Vaginal dryness and atrophy is recommended to be treated with non-hormonal lubricants. In refractory cases low dose vaginal estrogen therapy (eg, Estrinor or Vagifem vaginal tablet 10 microgram) can be used after discussing the risks with patients. Patients on Tamoxifen are at higher risk of developing endometrial cancer. Patients on Tamoxifen are recommended to have a yearly pelvic examination and close monitoring for signs and symptoms of endometrial cancer.