



NATIONAL OPTIMAL PATHWAY FOR METASTATIC BREAST CANCER:

2nd EDITION (2024)

Point of Suspicion to First Definitive Treatment in Adults (aged 16 and over)

Date of Issue: October 2024
Date of Review: October 2026
Owner: Breast Cancer Site Group

FOREWORD

The NHS Wales National Optimal Pathways (NOPs) have been developed as part of the Suspected Cancer Pathway (SCP) programme of work. They aim to establish consistent generic and site-specific pathways that describe all routes of entry, from the point of suspicion (PoS) of cancer. They describe good practice diagnostic and treatment pathways, the diagnostic pathway, including staging, should be performed within 28 days from PoS; and definitive treatment commenced within 21 days from date of Decision to Treat (DTT). The pathways also describe where patients should receive consistent information and support, tailored to meet their needs.

The NOPs aim to provide a platform to standardise care, reduce unwarranted variation and drive improvement whilst increasing quality across each of the cancer pathways in order to:

- meet the SCP cancer waiting time of 62 days for patients presenting with a suspicion of cancer,
- improve cancer patient experience, and,
- improve cancer patient outcomes throughout Wales to that comparable with the best outcomes in Europe.

The Metastatic Breast Cancer NOP is designed to help primary care, breast surgery, radiology, histopathology, oncology and palliative care service providers and their commissioners identify and provide what is needed to for an effective and efficient metastatic breast cancer service and to provide equity of that service across Wales. It aims to identify the key steps of a complete diagnosis of metastatic breast cancer, key worker provision and patient communication, offering patient-centred care throughout. The pathway aims to standardise the diagnosis and treatment of metastatic breast cancer across Wales, provide clarity and consistency for patients, primary care and breast cancer multidisciplinary teams, and ensure that patients move through the pathway in a timely manner.

It is recognised that the introduction of the National Optimal Pathway for Metastatic Breast Cancer may present administrative and resource challenges for breast cancer multidisciplinary teams. It therefore intends to identify and support resource prioritisation and provision and to support service improvement as a clinically-endorsed, nationally agreed pathway.

GROUP CONSULTATION

The Breast Cancer Site Group (CSG) is led by Mr Sumit Goyal, Consultant Breast Surgeon.

The development of a National Optimal Pathway for Metastatic Breast Cancer was agreed by the Breast CSG in January 2023. An open invitation was made to join the pathway working group. Senior clinicians representing Primary Care, Oncology, Radiology, Breast Surgery, Palliative Care, the third sector and patient representatives formed the working group, led by Miss Zoe Barber, Consultant Breast Surgeon. The working group were all able to contribute and comment on the development of the optimal pathway during a range of meetings. All members of the working group agreed to the final draft of the pathway.

Wider consultation was sought in August 2023 from NHS Wales stakeholders, all responses were received and these were all carefully considered during the revision process, prior to a final version being issued in November 2023. The 2nd edition of the 'NOP' has been up-dated to reflect the current versions of the infographics for ductal and lobular cancer and adopting feedback from the Breast cancer community to change the title of the 'End of Treatment Summary' to 'Breast Cancer Treatment Summary'. The code within the 'Breast Cancer Treatment Summary' has also been removed following advice from Digital Health Care Wales (DHCW).

Mr Sumit Goyal (Breast CSG Lead)

Miss Zoe Barber (Lead Clinician)

Professor Tom Crosby (National Cancer Clinical Director for Wales, National Strategic Clinical Network for Cancer)

Dr Jeff Turner (Clinical Lead Cancer Recovery Programme, Strategic Programme for Planned Care)

Bethan Hawkes (National Strategic Clinical Network for Cancer, Macmillan Lead Cancer Nurse)

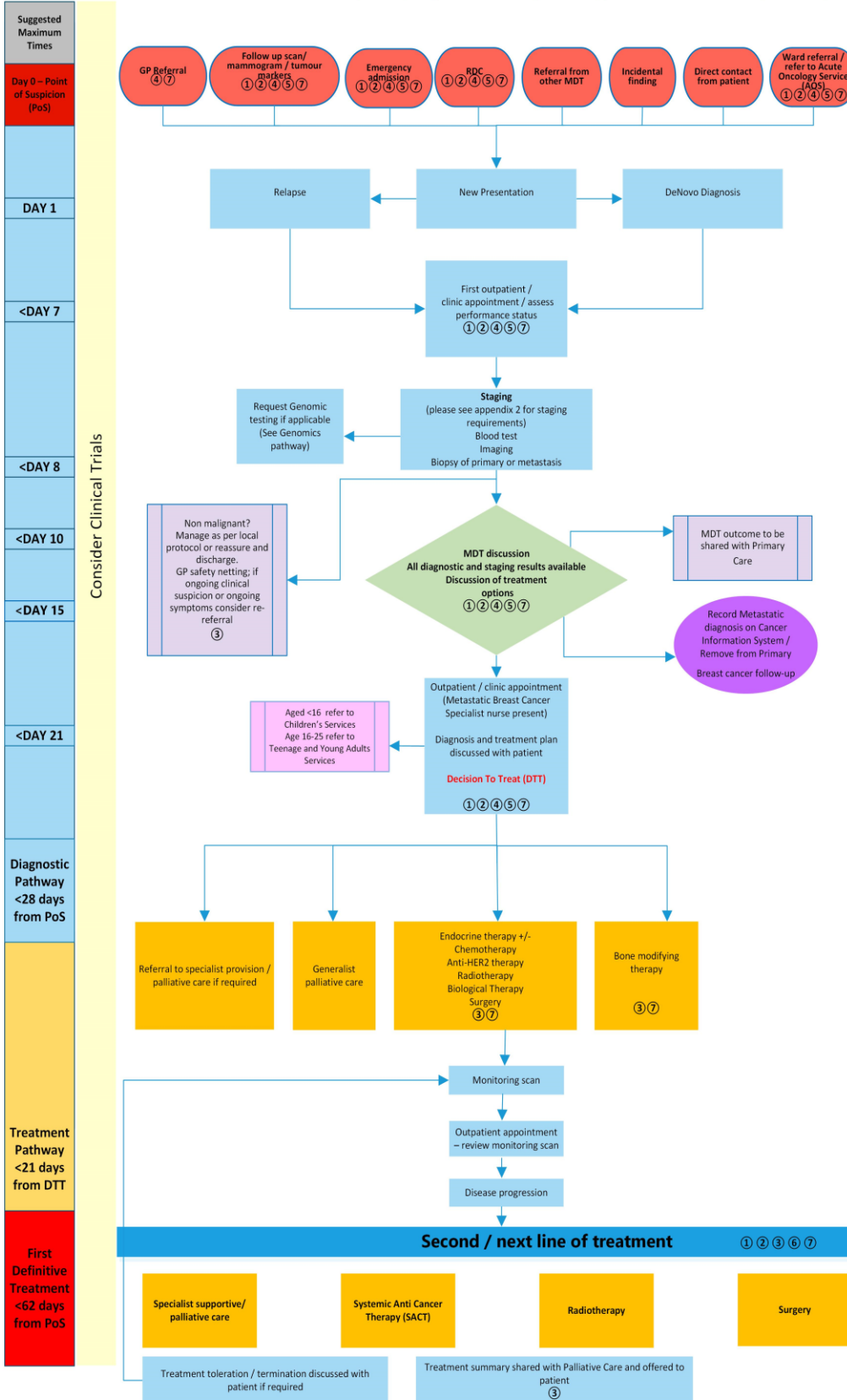
Bethan Jones (National Strategic Clinical Network for Cancer, Programme Manager)

Hannah Edwards-Jones (National Strategic Clinical Network for Cancer, Senior Project Manager)

Amy Smith (Programme Support Officer, National Strategic Clinical Network for Cancer)

Date 06/09/2024

National Optimal Cancer Pathway for suspected and confirmed Metastatic Breast Cancers:
 Point of Suspicion (PoS) to Treatment/Best Supportive Care for adult patients (16 and over)



Person Centred Care Key

- Key worker (allocation and transition – dedicated / Metastatic Breast Cancer Specialist nurse)
- Meeting People's Needs
- Treatment summaries
- Health optimisation/ Making Every Contact Count
- Prehabilitation
- Rehabilitation
- * Patient Reported Outcome Measures (PROMS)

* Please see narrative for details

Pathway Key

- Point of Suspicion
- Diagnostic Pathway
- GP safety netting or remove from the SCP
- MDT
- Discuss with TYA / Children's services
- Treatment Pathway
- Informatics and Intelligence

BIOMARKER TESTING

Breast cancer genomics is a rapidly-changing area. Appendix 1 includes current recommendations for testing, indications and targeted treatment available as a result. It will be updated as and when new genomic tests and targeted treatments become available.

RADIOLOGY STAGING INVESTIGATIONS

Appendix 2 includes radiological staging investigation recommendations to avoid multiple trips for patients to complete staging. For example, the importance of including the whole spine in an MRI, rather than only the area of clinical symptoms, and including the high chest (or neck if appropriate radiological resource locally) to include the supraclavicular fossae.

BREAST CANCER TREATMENT SUMMARY

Copies of the Breast Cancer Treatment Summary (Appendix 3) are to be uploaded to Welsh Clinical Portal, given to the patient and sent to the GP **at the end of surgical treatment** and again at the **end of oncological treatment for primary breast cancer**. This document is based on the evidence-based Greater Manchester end of treatment summary document, is agreed by the working group and has been produced with expert primary care input.

RED FLAG SYMPTOMS INFOGRAPHICS

Appendix 4 includes the Red Flag symptoms infographics which are reproduced with kind permission of Jo Taylor and ABCDiagnosis. It is validated, evidence-based and used in Greater Manchester. It has been translated into Welsh and other languages and these versions are available on the ABCDiagnosis website, available here: <https://www.abcdiagnosis.co.uk/resources/infographics/>. A copy to patients and their GP is to be included with the Breast Cancer Treatment Summary.

BEST PRACTICE GUIDANCE

Vetting & Triage	<p>It is recommended that the triage of referrals is undertaken using an electronic system (e.g. Welsh Patient Referral Service) to improve the timeliness, traceability and governance of pathways.</p> <p>Referrals received as suspected cancer (USC) should be prioritised within 1 day and urgent / routine referrals within 3 days due to the potential need for upgrade to suspected cancer (pathway entry date: date referral originally made by primary care).</p> <p>It is recommended for the patient to be discussed at the next available Breast MDT.</p>
MDT	<p>It is recommended patients attend a face-to-face outpatient clinic appointment as soon as possible after being discussed at MDT.</p> <p>The MDT to decide if the patient needs a second line investigation and identify a site for tissue biopsy.</p>
MDT recommended imaging	<p>It is recommended that following the MDT discussion, if further investigations are required the results are available within 10 working days, reported within 2 days and the results discussed at the next MDT.</p>
Key worker role	<p>It is recommended that patients are assigned a named dedicated secondary Breast cancer nurse.</p> <p>It is recommended that the key worker facilitates discussions with the relevant MDT members as timely as possible, without needing to wait until the next MDT meeting.</p>
Preservation of tissue for genomics	<p>It is recommended that the preservation of tissue for genomic testing is considered. Each Health Board can identify their own practice for this that is suited to local arrangements.</p>

DEFINITIONS

Decision to Treat	<p>The DATE on which a Decision To Treat is made. For the cancer data sets, the DECISION TO TREAT DATE is the DATE that the consultation between the PATIENT and the clinician took place and a Planned Cancer Treatment was agreed.</p> <p>Source: NHS Data Dictionary</p>
Direct to Test	<p>GPs have direct access to diagnostic endoscopy, ultrasound, MRI, X-ray and CT for people suspected of cancer.</p> <p>Source: National Institute for Health and Care Excellence, Quality Standard 2016 (QS 124)</p>
First Definitive Treatment	<p>First Definitive Treatment is the first CLINICAL INTERVENTION intended to manage a PATIENT's disease, condition or injury and avoid further CLINICAL INTERVENTIONS. What constitutes First Definitive Treatment is a matter of clinical judgement in consultation with others, where appropriate, including the PATIENT.</p> <p>Source: NHS Data Dictionary</p>
Next Generation Sequencing (NGS)	<p>The advent of next generation sequencing (NGS) technology has revolutionised the scale at which genetic testing can be performed, enabling the analysis of many more genes within the same assay. This allows multiple variants (mutations) to be detected per sample. Large gene panel tests (>500 genes) for cancer testing are rapidly being adopted in the UK.</p> <p>Source: Genome UK: the future of healthcare 2020</p> <p>AWMGS - Cymru Service for Genomic Oncology Diagnoses (CYSGODI) (medicalgenomicswales.co.uk)</p>
Safety Netting	<p>“Safety netting is a management strategy of patients, tests and referrals used in the context of diagnostic uncertainty in healthcare. It aims to ensure patients are monitored until signs and symptoms are explained or resolved.”</p> <p>Source: Royal College General Practitioners</p>
Straight to Test	<p>“Following clear referral criteria into secondary care (usually NICE guidance) the secondary care clinician (defined as per local protocol) will arrange a diagnostic procedure as the first episode of care in place of an outpatient episode. The clinician will retain clinical responsibility for the result including acting on the result.”</p> <p>Source: Delivering Cancer Waiting Times NHSE</p>
Teenagers and Young Adults (TYA) Service	<p>Young people (aged 16-24 years) with cancer have their diagnosis treatment and support agreed and delivered by a cancer-site specific multidisciplinary team and a teenage and young adult multidisciplinary team.</p> <p>Source: National Institute for Health and Care Excellence (NICE), 2014. Cancer services for children and young people (QS55)</p>

CLINICAL EVIDENCE

<p>Point of Suspicion/ Referral</p>	<p>The point of suspicion is when a clinician refers a patient or requests a test concerns a patient may have cancer. Pathway start dates are defined in the following guidance:</p> <p>Single Suspected Cancer Pathway Definitions (December 2018)</p> <p>Additional information:</p> <p>Cancer Risk Assessment Tool (RAT)</p> <p>Q Cancer Risk Assessment Tool</p>
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PERSON CENTRED CARE

Person-centred cancer care is culturally embedded and supported by a common approach to assessing and managing people’s needs and care should be co-produced to ensure people affected by cancer to achieve the outcomes that matter to them’ (Cancer Quality Statement, 2021).

<p>Key Worker</p>	<p>QS 14: Patients are made aware of who to contact, how to contact them and when to make contact about their ongoing healthcare needs. National Institute for Health & Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services</p> <p>A cancer key worker is <i>“a person who, with the patient’s consent and agreement, takes a key role in coordinating the patient’s care and promoting continuity, ensuring the patient knows who to access for information and advice”</i>.</p> <ol style="list-style-type: none"> 1. All cancer patients must have an allocated key worker 2. Allocation / Review of key worker to take place at key time points including: <ol style="list-style-type: none"> a. Around the time of diagnosis <i>*please note: allocation of key worker may occur earlier than time of diagnosis, if there is a very high level of suspicion of cancer e.g. evidence obtained via pathology, radiology, endoscopy.</i> b. Commencement of treatment <p>Key workers for cancer patients (Welsh Health Circular /2014/001) GOV.WALES</p> <p>Cancer Improvement Plan for Wales</p>
<p>Meeting People’s Needs</p>	<p>QS 4: Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.</p> <p>QS 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. National Institute for Health & Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services</p> <p>Assessment and discussion of patients’ needs for physical, psychological, social, spiritual and financial support should be undertaken at key points including:</p> <ul style="list-style-type: none"> • Around diagnosis <i>*please note: undertaking a Holistic Needs Assessment may occur earlier than time of diagnosis, if there is a very high level of suspicion of cancer e.g. evidence obtained via pathology, radiology, endoscopy; and it is supported by professional judgement.</i>

	<ul style="list-style-type: none"> • At commencement, during, and at the end of treatment. <p>National Institute for Clinical Excellence (NICE, 2004) CSG4 Improving Supportive & Palliative care for adults with cancer</p> <p>Ideally Holistic Needs Assessments should be undertaken electronically. Cancer Improvement Plan for Wales The Macmillan eHNA is <i>one</i> tool which is both valid and reliable. Snowden A & Fleming M (2015) Validation of the electronic HNA.</p>
<p>Health Optimisation / MECC</p>	<p>QS 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.</p> <p>National Institute for Health & Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services</p> <p>Health Optimisation refers to a proactive approach to supporting people who present to NHS services with concurrent comorbid health conditions (e.g. anaemia, diabetes), or health risk behaviours (e.g. smoking, physical inactivity).</p> <p>Welsh Government (2018) A Healthier Wales. Welsh Government (2015) Wellbeing of Future Generations Act.</p> <p>Making Every Contact Count (MECC), is a behaviour change approach that helps health and social care professionals to help people to improve their health and wellbeing through prevention and early intervention. phw.nhs.wales/about-us/board-and-executive-team/board-papers/board-meetings/2022-2023/30-march-2023/board-papers-30-march-2023/412a-board-20230330-strategic-plan-imtp-2023-2026/</p> <p><i>Lifestyle advice / resources are available from Making Every Contact Count (MECC)</i></p> <p><i>*Please note: Whilst addressing concurrent comorbidities and health risk behaviours is the responsibility of all health and social care professionals, at every contact throughout the pathway; earliest possible intervention may impact on cancer treatment choices / outcomes (especially in respect to tobacco smoking). National Institute for Clinical Excellence (NICE, 2018) NG92 NICE Guideline Stop Smoking Interventions and services.</i></p>
<p>Prehabilitation</p>	<p>All patients should be given multimodal prehabilitation advice and support covering physical activity, emotional wellbeing, eating well, stopping smoking and reducing alcohol intake prior to undergoing treatment in order to enhance patient outcomes. Patient needs and goals should be evaluated on an individual basis and appropriate levels of support, from universal self-management advice to specialist support which includes timely access to allied health professional should be provided.</p> <p>Patients should have the opportunity to take part in evidence-based education and rehabilitative activities, including self-management programmes, <i>where available</i>, that promote their ability to manage their own health if appropriate.</p> <p>National Institute for Health & Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services Welsh Government (2018) A Healthier Wales. Welsh Government (2015) Wellbeing of Future Generations Act. The Quality Statement for Cancer.</p>
<p>Rehabilitation</p>	<p>All patients will have their needs for rehabilitation services assessed, with referral to an appropriate level of rehabilitative support, throughout the patient pathway including timely access to allied health professional to meet individual holistic patient needs and goals.</p> <p><i>*Please note: not all patients will require specialist cancer rehabilitation services. Referral into non-cancer rehabilitation, self-management, and fitness services may be suitable to meet some patients' needs.</i></p>

	<p>National Institute for Health and Care Excellence (NICE) CSG4 (2004) resources for improving supportive and palliative care for adults with cancer.</p>
<p>Patient Reported Outcome Measures (PROMs) / Patient Reported Experience Measures (PREMs)</p>	<p>Patient Reported Outcome Measures (PROMs) are questionnaires that patients are asked to complete before and after treatment to assess the impact on health and wellbeing.</p> <p>Some of the Cancer Site Groups (CSGs) have been working with the International Collaboration for Health Outcome Measurement (ICHOM), Value Based Healthcare Team, National PROMS, PREMS, & Effectiveness Programme (NPP&EP) and other partners, to pilot tools and data capture methods, which will inform a consistent approach to PROMS & PREMS for cancer. The Quality Statement for Cancer</p> <p><i>*Please note: there are outstanding questions relating to tool selection, data capture intervals, data capture methods and data analysis / reporting which may prevent the implementation of PROMS & PREMS across all pathways at this time. PROMS & PREMS have been included in the pathways, in recognition of this work, and will be updated pending further advice from the CSGs.</i></p> <p>Patient Reported Experience Measures (PREMs) are questionnaires that patients are asked to complete at any time during their pathway to help professionals to understand their experience of NHS services. This information is crucial to understanding the value of healthcare as perceived by patients. Welsh Government (2018/19). Chief Medical Officer Annual Report</p> <p><i>*Please Note: Whilst it is good practice to collect PREMS throughout the pathway, there is no current standard for cancer PREMS in Wales; further advice regarding this will be sought via the CSGs in due course.</i></p>
<p>Communication</p>	<p>Clinicians must ensure patients are kept up to date about their care pathway and are supported to make individualised choices about their treatment.</p> <p>Clinicians should consider the value of interventions and discuss with the patient the likely outcome of treatment options.</p> <p>Clinicians in secondary and tertiary care must ensure that all decisions relating to a patient's care or treatment are communicated to the patient and their primary care clinician in a timely manner and within 24 hours of diagnosis.</p> <p>Clinicians must ensure that the clinical intention of any intervention such as tests or treatment is clear to patients, and whether it is just a stage of the agreed pathway or considered start of first definitive treatment and as such ends the pathway.</p> <p>Clinicians must make contemporaneous records of discussions and decisions and include reasons for deviations from recommended clinical practice in the patient's clinical record. Decisions should be made in a timely manner, and any onward referrals be completed promptly, according to local/national guidelines and optimal pathways and include adequate information to allow the receiving clinician to initiate appropriate interventions with the minimum of delay. Referrers must ensure that the patient is aware and agrees for a suspected cancer referral to be made.</p> <p>Suspected cancer pathway: guidelines (WHC/2023/025) GOV.WALES</p>

	<p>Treatment Summary</p> <p>A treatment summary is a tool to improve communication between cancer services, primary care, and cancer patients. The treatment summary document is produced by secondary care and contains information about a patient’s cancer history (e.g., diagnosis and treatment).</p>
Research	<p>Patients should have the opportunity to take part in research and clinical trials where available.</p> <p>People in research Health Care Research Wales (healthandcareresearchwales.org)</p> <p>EC Trial Finder ECMC (ecmcnetwork.org.uk)</p>

APPENDIX 1: GENOMICS TESTING

Biomarker	Breast cancer subtype	Detection	NICE approved agent	Recommended timing of test
PIK3CA	HR-positive/ HER2-negative	NGS, tissue	Alpelisib	During first line therapy
NTRK	Any	NGS, tissue	Larotrectinib Entrectinib	When no satisfactory alternative treatments available
DPYD	Any	ARMS PCR, blood	Toxicity of fluoropyrimidine based chemotherapies	Prior to commencing fluoropyrimidine based chemotherapies

APPENDIX 2: RADIOLOGY STAGING INVESTIGATIONS

Investigation	Essential	Desirable	Additional notes
CA 15-3 blood test	√		
Identify a suitable site for biopsy	√		Breast MDT to identify the most suitable site for tissue diagnosis and receptor/genomic profiling
CT high thorax, abdomen and pelvis	√		
CT high thorax, abdomen, pelvis (including neck)		√	Include if there is radiology resource within the Health Board
MRI Head		√	Include if brain symptoms are of clinical concern
PET scan	√		On an individual patient basis
Baseline bone scan		√	Include if unexplained MSK symptoms
MRI whole spine		√	Include if there is clinical or radiological suspicion of metastatic spinal cord compression

APPENDIX 3: BREAST CANCER TREATMENT SUMMARY

Patient name:

Date of birth:

NHS number:

Address:

Thank you for coming to clinic today.

Please find below the summary of your diagnosis, treatment and the ongoing management plan that we discussed. A copy of this has also been sent to your GP. Everyone's management plan is different, as it is based on their diagnosis and treatment. This plan is specific to your needs.

This treatment summary has been designed to increase your knowledge and wellbeing and to help you move forward now that your initial treatment has finished. Please remember that if you do feel anxious or would like further advice at any time you are welcome to contact your Breast Care Nurse who can recommend a wide range of resources and services that have been designed to help you.

If you have any concerns regarding new breast symptoms in the future, please contact your Breast Care Nurses (details below) who will be able to advise you and arrange an appointment in breast clinic if needed.

Information for your GP:

Please find attached the primary breast cancer treatment summary.

Please code the cancer diagnosis and key worker.

Please be aware of the treatment plan, follow up plan and potential treatment side effects.

Of note, if the patient has any new breast concerns at any time after a previous breast cancer diagnosis, please advise them to contact their Breast Care Nurses (details below).

Contact details:

Breast Care Nurse name(s):	
Breast Care Nurse contact number(s):	

Breast cancer diagnosis details:

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Date of diagnosis:	
Final histology:	

Treatment completed prior to surgery (neoadjuvant) – please tick:

None	
Chemotherapy	
Anti-Her-2 therapy	
Hormone (endocrine) treatment	
Radiotherapy	
Other (please specify):	

Surgery:

Date:		Surgery:	
Date:		Surgery:	
Date:		Surgery:	

Further treatment after surgery (adjuvant treatment) – please tick:

None		Leaflet given?	
Radiotherapy		Leaflet given?	
Hormone (endocrine) treatment (name and planned duration): _____		Leaflet given?	
Chemotherapy		Leaflet given?	
Anti- Her-2 therapy		Leaflet given?	
Bisphosphonates		Leaflet given?	

Planned follow up:

Annual mammograms for 5 years	
Annual mammograms until age 50	
Clinical review (please state frequency and duration):	

After you have completed your planned follow up:

- You will be invited for national breast screening (mammograms every 3 years between the age of 50 and 70)

If you have had both breasts removed (a bilateral mastectomy) and are invited for breast screening, ask your breast screening unit for an opt-out letter or your GP can write to the Breast Screening Unit to inform them you do not require screening.

Possible Side Effects from the treatment(s) you have had

Some side effects can improve quickly, however some, such as fatigue, may take longer to improve. **If you are struggling to cope with side effects, or if the side effects are getting worse rather than better, please contact your Breast Care Nurse for advice.**

Possible side-effects from surgery

- Changes in the look and feel of the breast, chest wall or armpit due to scarring from surgery.
- Numbness and/or long-term pain/discomfort around the site of surgery and upper arm.
- Fluid build-up in the arm, hand or breast (lymphoedema) - please contact your Breast Care Nurse if this occurs so that they can arrange further assessment.

Possible side-effects from endocrine treatment

- Hot flushes.
- Aches and pains in joints.
- Feeling of tiredness or exhaustion (fatigue).
- Mood swings.
- Reduced libido (sex drive) and vaginal dryness. There are lots of treatment options for this so please do not feel embarrassed to talk to your Breast Care Nurse or GP.

Possible side-effects from radiotherapy

- Changes in the appearance of the breast, skin or nipple.
- Tiny visible blood vessels on the skin surface (often called 'spider veins' or 'telangiectasia').
- Long-term pain or discomfort of the breast or chest wall.
- Fluid build-up in the arm, hand or breast (lymphoedema) – please contact your Breast Care Nurse if this occurs so that they can arrange further assessment.
- Feeling of tiredness or exhaustion (fatigue).

Possible side-effects from Herceptin

- Feeling of tiredness or exhaustion (fatigue).

- Joint and muscle pains.
- Flu-like symptoms.
- Heart problems – your heart will be carefully monitored whilst taking Herceptin.

Possible side-effects from chemotherapy

- Feeling of tiredness or exhaustion (fatigue) (may persist for several months after chemotherapy).
- Difficulty with concentration and memory (may persist for 1-2 years after treatment).
- Tingling, numbness or pain in fingers and toes (known as 'peripheral neuropathy').
- Increased risk of early menopause or infertility.
- Rare risk of developing second malignancies.

Possible Immediate effects from Bisphosphonates

- Feeling of tiredness or exhaustion (fatigue).
- Flu-like symptoms.
- Poor blood supply to the jaw (Osteonecrosis). This is a rare side effect. If you have persistent jaw pain, loose teeth, swelling, redness or ulcers on the gums you should inform your Breast Care Nurse and see your dentist urgently.
- Thigh bone (femoral) fracture. This is a rare side effect. If you have persistent pain in your thigh, hip or groin, you should inform your Breast Care Nurse.

What can be done to reduce the risk of breast cancer returning?

- **Taking medication as advised**
- **Regular physical activity**
- **Maintaining a healthy weight**
- **Reducing alcohol intake**
- **Stopping smoking**

Your Breast Care Nurse can give you details of support with any of the above.

APPENDIX 4: RED FLAG SYMPTOMS INFOGRAPHICS

Symptoms of possible recurrence that will require investigation.

Recurrence is uncommon but occasionally breast cancer can return in the breast, chest wall or armpit (**local recurrence**) or in a different part of the body (**secondary breast cancer**).

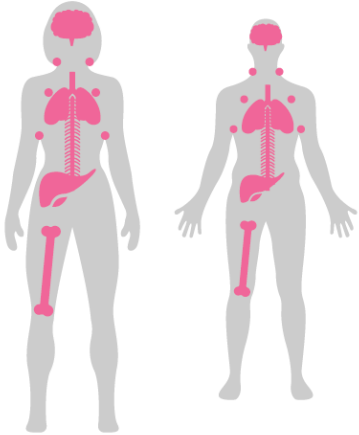
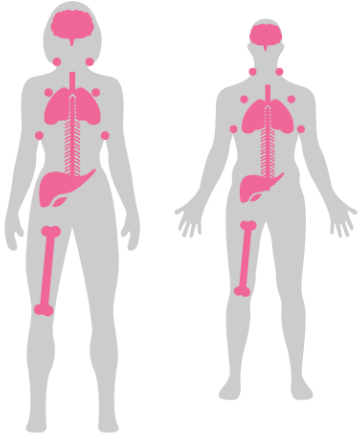
If you notice any new lumps in your breast (either side), armpit, or mastectomy scar, or new changes to the breast shape, skin or nipple, it is important that you contact your Breast Care Nurse to arrange assessment.


The infographics below shows the possible symptoms of secondary breast cancer. If you experience these symptoms, with no obvious other cause (e.g. a common cold, a back injury etc) they need to be reported to your Breast Care Nurse.

Secondary / Metastatic (ductal) Breast Cancer

Also known as metastatic or advanced breast cancer


After primary breast cancer be aware of these **RED flags*** for secondary breast cancer. There are 5 main areas that secondary breast cancer can appear.






BRAIN

Frequent headaches, vomiting (first thing in the am), dizzy, visual disturbance, seizure, impaired intellectual function, impaired motor skills, mood swings, balance, fatigue. Family members and friends may say you are not your normal self.




LYMPH NODES

Swelling or lumps and pressure in chest/armpit/neck areas, dry cough.




LIVER

Bloating, affected appetite, weight loss, fatigue, weak, pain near ribs on right hand side.




BONE

Pain in bones — commonly thigh, arm, ribs and back. Can be dull ache or sharp shooting pain. Bone pain with no obvious cause or trauma. Report any new, unusual or increasing pain.



LUNG

Sharp pain on breathing in chest and back area, non productive cough, fatigue, blood clots can also cause shortness of breath.




SPINAL CORD COMPRESSION

Rare but more common in breast cancer needs **URGENT** treatment

Pain or tenderness in middle or top of the back or neck, severe pain in lower back that gets worse or doesn't go away, pain in back that is worse when coughing, sneezing or straining, back pain that's worse at night, numbness, heaviness, a band of pain around the chest or abdomen or pain down an arm or leg, changes in sensation, for example pins and needles or electric shock sensations. **Contact your clinical team ASAP if you have these following symptoms** - weakness or difficulty using arms or legs, numbness in the area around the back passage (the saddle area), not being able to empty the bowel or bladder, problems controlling the bowel or bladder.

Please visit: abcdiagnosis.co.uk
Twitter: [@abcdiagnosis](https://twitter.com/abcdiagnosis)
Facebook: facebook.com/abcdiagnosis

***IF THE RED FLAG PROBLEM PERSISTS MORE THAN 3 WEEKS CONTACT YOUR MEDICAL TEAM DIRECTLY**



After Breast Cancer Diagnosis

© 2020 After Breast Cancer Diagnosis. ABCDiagnosis SBS (Ductal) Red Flags Infographic v9. Produced 24/02/2020. Please check website for latest version - www.abcdiagnosis.co.uk/resources/infographics/

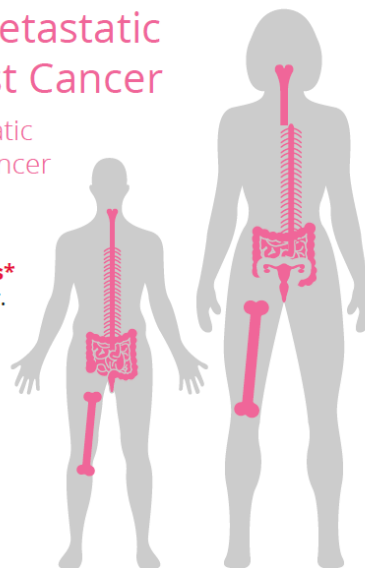
Secondary / Metastatic (lobular) Breast Cancer

Also known as metastatic or advanced breast cancer

After primary breast cancer be aware of these **RED flags*** for secondary breast cancer. There are 3 main areas that secondary breast cancer can appear.

***SYMPTOMS CAN MIMIC OTHER CANCER SO BE AWARE. IF THE RED FLAG PROBLEM PERSISTS MORE THAN 3 WEEKS CONTACT YOUR MEDICAL TEAM DIRECTLY**

Please visit: abcdiagnosis.co.uk
Twitter: @abcdiagnosis
Facebook: [facebook.com/abcdiagnosis](https://www.facebook.com/abcdiagnosis)



GYNAECOLOGICAL TISSUE

Can be vague and not specific but mimic other cancers or common illnesses- Abdominal/pelvic pain, uterine/pelvic bleeding, abdominal swelling/bloating and/or a sense of fluid in the abdomen, hot flushes, leg swelling, bone pain, shortness of breath.



BONE

Pain in bones — commonly thigh, arm, ribs and back. Can be dull ache or sharp shooting pain. Bone pain with no obvious cause or trauma. Report any new, unusual or increasing pain.



GASTROINTESTINAL

Can be vague and not specific but mimic other cancers or common illnesses - difficulty swallowing, abdominal pain, symptoms of a bowel obstruction, feeling full early when eating, changes to appetite, nausea and/or a sense of fluid in the abdomen, leg swelling, bone pain, shortness of breath.



SPINAL CORD COMPRESSION

Rare but more common in breast cancer needs **URGENT** treatment

Pain or tenderness in middle or top of the back or neck, severe pain in lower back that gets worse or doesn't go away, pain in back that is worse when coughing, sneezing or straining, back pain that's worse at night, numbness, heaviness, a band of pain around the chest or abdomen or pain down an arm or leg, changes in sensation, for example pins and needles or electric shock sensations. **Contact your clinical team ASAP if you have these following symptoms** - weakness or difficulty using arms or legs, numbness in the area around the back passage (the saddle area), not being able to empty the bowel or bladder, problems controlling the bowel or bladder.

OTHER SYMPTOMS

LIVER: Bloating, affected appetite, weight loss, fatigue, weak, pain near ribs on right hand side.

LUNG: Sharp pain on breathing in chest and back area, non productive cough, fatigue, blood clots can also cause shortness of breath.

BRAIN: Frequent headaches, impaired motor skills, vomiting (first thing in the am), dizzy, visual disturbance, seizure, impaired intellectual function, mood swings, balance, fatigue. Family members and friends may say you are not your normal self.

EYE (very rare): Vision changes — especially unilateral, swelling, pain.

Make sure you always tell your doctor that you have a history of Lobular BC in addition to symptoms or take this pdf along to any appointment and explain LBC is more common to spread to the bones, GI tract or ovaries.

For additional information please visit www.abcdiagnosis.co.uk