NCG GUIDELINES- 2019
Breast Cancer
Management Guidelines

Categories of the guidelines

a) Essential
b) Optimal
c) Optional

**Herewith essential will be referred as (a), optimal as (b) and optional as (c)*

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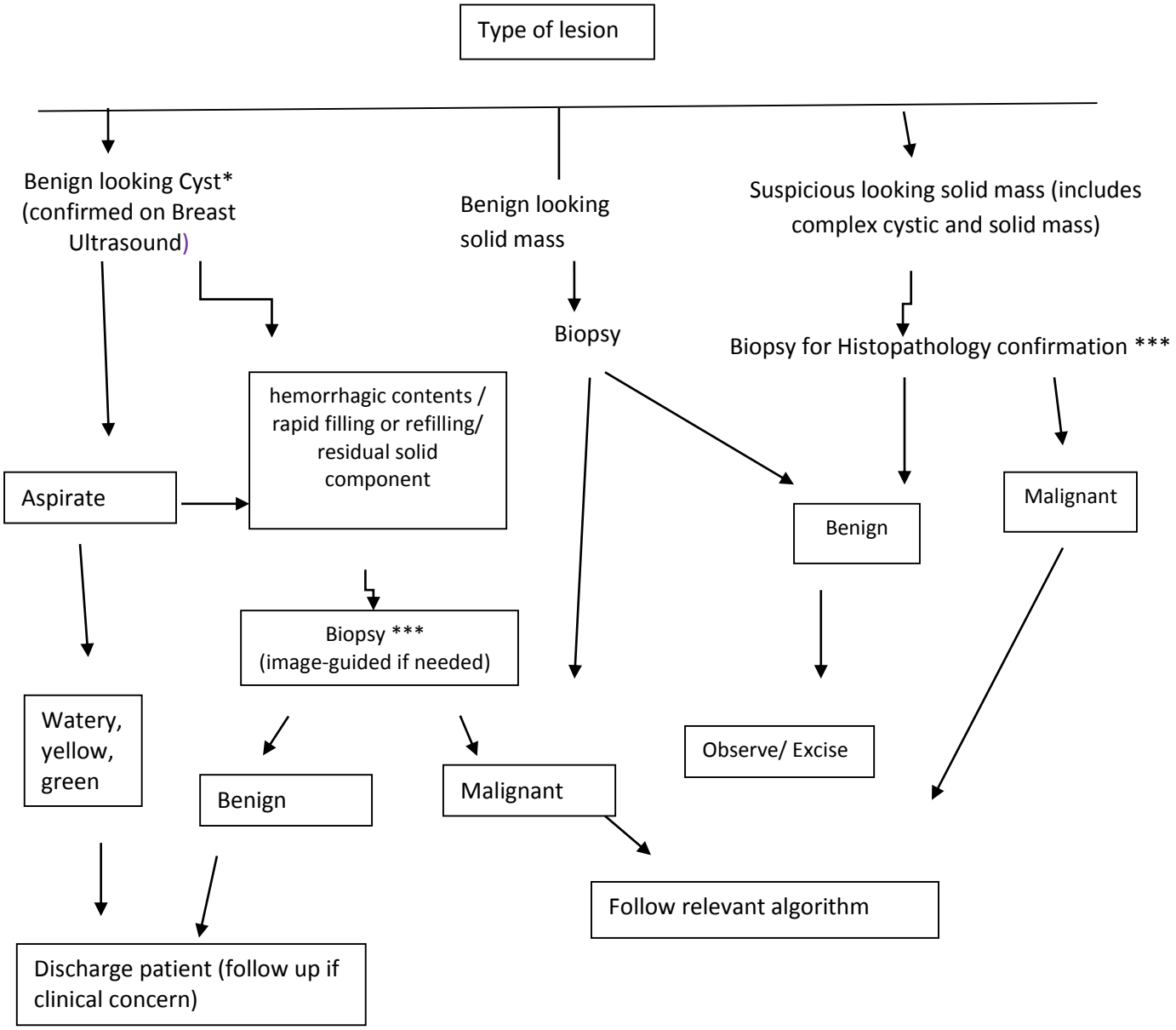
EVALUATION OF A BREAST LUMP

All women with a breast lump should undergo a <u>TRIPLE TEST (a)</u> comprising of

1. Clinical Examination by an experienced clinician preferably a breast surgeon
2. Bilateral imaging: a bilateral mammogram (a) and/or Ultrasound (a)/ MRI as appropriate (c) ##
3. Histopathology** (Core biopsy preferred (b) or FNAC (a))[#] Incisional biopsy may be considered in exceptional cases



*Solitary and multiple simple cysts can be observed and do not need to be aspirated.

***Core Biopsy is preferred in cases where neo-adjuvant therapy is planned (for grading and receptor status) and for guided non palpable-lesions and if MRM considered. FNAC is acceptable if patient cannot afford Core Biopsy. IHC evaluation is mandatory prior to neo adjuvant therapy. Histo/cyto pathology confirmation is a MUST before initiating cancer directed treatment (surgery/ chemotherapy/ other systemic treatment). Exception: in case where frozen section is required for primary diagnosis

Primary diagnostic procedure should not be Excision Biopsy prior to failure of routine procedures.

In cases of discordance in triple test, further evaluation must be considered.

MRI breast may be considered in cases with extremely dense breast with clinical or imaging based suspicion of multiple tumors, high risk women with dense breast.

Management Schema for Operable breast cancer (Tis, T1-2, N0-1, M0)

Clinical diagnosis of operable breast cancer

Histopathological confirmation; breast and axilla imaging as appropriate (if for NACT : core biopsy) (a)
Staging investigations not indicated in cT1-2, N0-1, M0, unless specific symptoms suspicious of metastases

- Wishes for and is eligible for BCS
- Wants BCS but not eligible presently (large T size or inadequate breast vs tumor ratio) NACT not indicated Tis
- Not eligible[ii] or doesn't want BCS

Neoadjuvant chemotherapy (b) [iii]
(Re-asses with clinical evaluation after every cycle confirming maximal response(a))

Eligible / Not eligible

- Breast conserving surgery/ BCS +/- Oncoplasty (b)
- mastectomy +/- Whole breast reconstruction (b) iv

Adjuvant chemotherapy, radiotherapy, hormone therapy or targeted therapy as indicated
(Refer to page 10-18)

Approach to axilla

- Clinically node negative axilla (no palpable nodes/ no enlarged nodes on MMG/US)
  - **Upfront surgery**
  - Sentinel lymph node biopsy/low axillary sampling, send for frozen (b) [v]
    - Node negative
      - T1/T2 – stop at sampling or SLN (b)
      - Final paraffin section node positive → Complete axillary clearance (Level I to III) (b)
    - Node Positive → Complete Axillary Dissection. (Sentinel lymph node biopsy/low axillary sampling directed management of axilla may be done if criteria met(c)
- Clinically node positive axilla
  - **Post NACT [vi]**
  - Clinically N0 → Complete axillary clearance (a)

i. Bilateral mammogram (a) and/or Ultrasound (a)/ MRI as appropriate (c)

a. MRI breast may be considered in cases with extremely dense breast with clinical or imaging based suspicion of multiple tumors, high risk women with dense breast
b. USG axilla for cN0 cases (b)
c. In patients with family history of cancer, younger than 40 years, male breast cancer or patients with synchronous and metachronous breast cancer, can be referred for genetic counselling and those who are willing may be considered for testing to rule-out presence of germline pathogenic variant(c)

ii. Number of cycles should be based on tumor response/ institutional practice

iii. Tailoring treatment based on IHC, to be able to consider post NACT adjuvant therapy to non-responders can be discussed with patients(c). In TNBC, use of adjuvant capecitabine in those who don't achieve pCR , in Her2neu positive , use of adjuvant TDM1 in in those who don't achieve pCR.

iv. Contraindications to BCS include: diffuse micro calcification, persistent positive margins, poor patient compliance, previous chest or breast radiation, relative contraindication is multicentricity. Contra-indications to radiotherapy e.g. collagen vascular diseases.

a. Margins in BCS: negative margin defined as no tumor on inked surface. In case of positive margins, should be revised. In case of persistent positive margins, MRM to be considered
b. Breast reconstruction may be performed by surgeons in motivated and suitable patients following mastectomy. Implant or autologous flap reconstruction can be performed based on patient's suitability and choice of surgeon

v. SNB can be performed either using dual dye- radio colloid and blue dye (preferred method) OR using blue dye alone. 1 to 2 ml peri-tumoral and/or sub-areolar injection / sub-dermal injection of patent blue dye or 2% methylene blue 10 minutes prior to the surgical incision and 40 MBq

in 0.5ml of 99m-technetium–labelled sulphur/ antimony colloid peri-tumoral and/or sub-areolar injection / sub-dermal injection 2 to 12 hours prior to surgery.

a. If the Patient and Tumor characteristics meet the ACOZOG Z-11 (T1, micro metastasis in node, Low grade tumor, ER /PR positive, BCS done, whole breast RT using tangential fields planned) and 1-2 SLN positive, no further axillary surgery may be considered (c).

vi. If cN0 prior to NACT or an OBC with cN1 post chemotherapy cN0: can be considered for SLN/ Low axillary sampling

a. Screen detected Low grade DCIS undergoing lumpectomy may not require axillary assessment (c).

Management Schema for locally Advanced breast cancer (T3-4, any N, N2-3 any T)

Clinical diagnosis of advanced breast cancer

Histopathological confirmation with core biopsy and breast imaging as appropriate (a)

(Clip placement (b), skin marking (a) to localize the primary tumor prior to NACT)

Metastatic work up (a)
(X-ray Chest, USG abdomen and pelvis, LFT (a) Bone Scan, CECT CHEST /ABDO (b) PETCT(c))

- No Metastatic disease
  - Modified radical mastectomy with primary closure (a)
    - Feasible
      - Modified radical mastectomy
    - Not Feasible or patient keen on BCS
      - Neoadjuvant therapy (b)
        - Neoadjuvant chemotherapy(b) (Re-asses with clinical evaluation after every cycle confirming maximal response (a)) *
          - MRM or BCS as feasible
          - No response
            - MRM or second line chemotherapy based on operability
- Metastatic disease
  - Follow algorithm for metastatic breast cancer

Completion of Adjuvant systemic therapy, radiotherapy, hormone therapy or targeted therapy