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Association of Breast Surgery: Position Statement on Breast Pain

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Background

Over the past decade referrals of women to breast cancer diagnostic clinics (also known as "one stop clinics" (OSCs)) have grown by almost 100% (1, 2), a rise which has not been mirrored by an increase in breast cancer diagnoses, which have increased by 14% (3). This was highlighted in the recent breast Getting it Right First Time (GIRFT) report (4). To deal with the upsurge in referral numbers many units are undertaking extra OSC in evenings or weekends (5) but despite best efforts up to 51% of breast units are now failing to see patients within the 2 week target standard (6). Drivers behind the increased referral numbers are multifactorial in aetiology but do suggest that there are many women referred to breast cancer diagnostic clinics who could be better served outside of the OSC and avoid the inevitable anxiety of referral to a 'breast cancer clinic'.

Women with breast pain constitute up to 41% of attendees in OSC. (7,8) The incidence of breast cancer in women with breast pain only symptoms (no lumps, nipple or skin symptoms) is 0.4%, as reported both in the largest consecutive series of women attending a symptomatic breast clinic (9), and in the most recent literature review (10), but reports in the literature vary (11, 12). This figure is approximately half the detection rate in asymptomatic women screened by the national breast screening programme (9.2 per 1,000 women screened in 2021-22)). During the COVID-19 pandemic NHS England stated that "Based on NG12, in the absence of associated red flag symptoms, i.e. lump or skin changes, breast pain alone is not a symptom of cancer and should not be automatically referred on an urgent cancer pathway."(13)

Despite this evidence, many women perceive that breast pain is associated with an increased risk of breast cancer. At the same time, some General Practitioners are concerned regarding their potential risk if they do not refer a woman, particularly if the patient is voicing concern regarding a cancer diagnosis. Hence referrals of women with breast pain are a significant contributor to the workload in OSCs.

Better care for women with breast pain

The Association of Breast Surgery (ABS) believes that women with breast pain require and deserve management by skilled clinicians, who can address the presenting complaint of breast pain and manage this appropriately. Time is also needed to give advice on the management of symptoms and address patient concerns, which is difficult in a pressured OSC. The OSC may not be the appropriate place to see patients with breast pain only, as it is a service designed to diagnose breast cancer. Referral to a cancer diagnostic clinic may increases anxiety inappropriately, and may also lead to excess imaging. Within a busy OSC, with its focus on diagnosing cancer, the necessary time required to reassure and inform women about breast pain and symptom control is limited. The very problem with which the patient is referred is not effectively addressed.

Better care for all women with breast symptoms

As noted above, a significantly increased number of patients referred to the OSC has resulted in delays in being seen for all women, including those with red-flag symptoms of breast cancer such as breast lumps. This is highly unsatisfactory for these women and their healthcare professionals. An alternative high quality, safe and effective pathway for women with breast pain only, outside of the OSC, would allow greater capacity for rapid review of women with red-flag symptoms (breast cancer incidence 5-6%) within the OSC.

ABS Working with NHS England on the Faster Diagnosis Breast Pathway

The ABS are currently working with NHS England on the breast pathway for the new Faster Diagnosis Standard. We have presented our viewpoints and the evidence and hope that the new pathway will recommend stratification of new patient breast referrals to allow best use of the scarce one stop clinic resource. This should also allow for more appropriate bespoke care for patients with breast pain and other breast presenting symptoms.

Breast Services have found local solutions

A number of breast services have developed their own local solutions outside of OSCs, involving assessment of women with breast pain only, freeing up capacity within these clinics for women with true red-flag symptoms. There are a number of different pathways across the UK and Ireland, which are currently being evaluated. These include:

- **Telephone breast pain clinic:** This might be followed by a mammogram in women aged over 40 based on local protocols. Diversion into the OSC is actioned if the referral does not meet criteria
- **Dedicated breast pain clinic:** This is a face-to-face clinic model, either in the community with no one-stop imaging or within the tertiary care setting, which might be followed by a mammogram in women aged over 40 based on local protocols.
- **GP Managed:** This is managed by GPs working in the community. There will be no access to imaging. If clinically indicated, then referral to the breast clinic will be made, depending on local protocols and systems.
- **Self-managed:** Patient information is sent out following receipt of the referral, with advice and guidance, along with an opportunity to request an appointment if there are ongoing concerns within a given timeframe of the referral (usually 3 months).
- **Imaging only:** There is no clinical encounter, either virtual or face-to-face. A mammogram appointment is made for women over 40.

No innovation without evaluation

All units who have developed new assessment pathways for women referred with breast pain are reminded of their obligation to evaluate the new pathways to ensure safety, effectiveness and patient satisfaction. We are aware that different pathways have been evaluated in different ways, and some have presented and published their evaluation. Engaging with Aspire is one way in which you can get your innovative pathways assessed.

Obtaining the best evidence

While these pathways have the potential to improve outcomes for both patients with breast pain and those with cancer, they are all very different in terms of organisation of care and components of assessment. It is therefore vital that they are robustly evaluated to ensure they are safe, effective and meet the needs of patients using the service. In parallel to the above, ABS has convened a breast

pain working group to consider the available published evidence and develop ideas to improve the evidence base by evaluating the pathways. The ABS has established a platform for the evaluation of the breast pain pathways across the UK, to allow for a standardised approach; the ASPIRE project. Standard data collection allows uniform reporting of the various pathways as described above. Outcomes from evaluation of these new pathways will also be reported alongside the current/historical practice of seeing patients in the one stop clinic. This is being run as a national collaborative service evaluation, which allows relatively speedy set up, pragmatic assessment and data collection of very large numbers of patients. The platform study design allows for the inclusion of multiple pathways for evaluation as and when they arise. ABS proposes that all breast services that have developed or are developing new assessment pathways for women with breast pain become part of a robust service evaluation. This will allow rapid accumulation of outcome data and prompt cross fertilisation of best practice.

Summary

1. Women with breast pain may not be best served by current referral pathways, which can raise anxiety but fail to offer the opportunity to address underlying concerns and symptom management.

2. ABS are working with NHS England and Breast Cancer charities to develop more appropriate pathways out-with the one stop clinic.

3. New pathways should be evaluated assiduously with standard data collection

4. ABS will continue to promote and facilitate collection of best evidence as part of the ASPIRE project

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