

STATEMENT FROM THE ASSOCIATION OF BREAST SURGERY, 15TH MARCH 2020

CONFIDENTIAL ADVICE FOR HEALTH PROFESSIONALS

Breast Service Provision

These are extremely difficult times for everyone in the health service. Although our aim would be to run a normal breast service, it is unlikely that we are going to be able to do this in the coming weeks. We suggest that you develop a plan now so that this can be implemented as the pandemic worsens. With the potential shortage of medical staff and theatres, we are all going to have to adapt and prioritise the order in which breast cancer patients receive surgical treatment.

Triage of referrals and change to treatment are likely to be necessary and we would recommend that you consider the following measures to include in your plan:

GP Referrals to Clinic

Letter to go out with breast clinic appointment stating that if the patient has fever, cough or respiratory symptoms to phone and they will be given another appointment. They must self-isolate for 7 days and then they will be seen in clinic. They should also be advised that only one person may accompany them to the clinic.

Triage all referrals

- See only referrals where there is a higher index of suspicion of cancer, providing there are staff to run clinics.
- Write to or phone referrals with a lower index of suspicion of cancer e.g. breast pain
- Very frail elderly patients, especially if in nursing homes, referred with suspicious lumps should not be seen in clinic until the situation has changed. If the Government introduces self isolation for people 70 and over then consideration should be given as to whether these patients should be seen in the clinic. Older patients especially with co-morbidities are at highest risk of death from coronavirus and they should be seen once the pandemic is over. Start on endocrine therapy empirically.

New Cancer Patients

- Clip put in all cancers when biopsy performed
- Aim for day case surgery in majority of patients
- If theatre space is limited, surgical priority given to ER negative patients first.
- Then HER2+ patients
- Then pre-menopausal ER+ patients

- For DCIS patients if theatre space available prioritise high grade DCIS
- Neoadjuvant chemotherapy only for inoperable disease, NOT to downstage from mastectomy to BCS or to perform axillary conservation in ER- or HER2+ patients.
- No immediate breast reconstruction. Mastectomy and delayed reconstruction being offered at a later date
- If insufficient theatre capacity, post menopausal ER+ patients to be commenced on primary endocrine. If not enough theatre capacity pre-menopausal ER+ patients may also have to be commenced on primary endocrine therapy
- Discuss with oncology whether all grade 3 or node positive ER+ positive patients should have genomic testing performed on the core biopsy. If a high score to have surgery as would normally need adjuvant chemotherapy. Currently genomic testing is not re-imbursed in this situation, but this will need to be re-considered.
- Clearly document why these decisions have been made

Follow up cancer patients

- Try to minimise the number of patients attending breast clinics for routine review. Postpone appointments where appropriate and consider introducing telephone reviews for those where review is required
- This is especially important for frail elderly patients on primary endocrine treatment

Benign disease

- No surgery for benign disease or risk -reduction to be performed

MDT Meetings

- Maintain weekly MDT; can be done remotely if needed. Aim to minimise the number of staff present at the MDT. Perhaps 1 surgeon, 1 oncologist, 1 pathologist, 1 radiologist and one breast care nurse.
- Maintain a list of patients with surgical delay on primary endocrine therapy.

Research Activity

- Follow local guidance

Also

- Liaise with other disciplines
- Liaise with your Oncology colleagues regarding the feasibility and practicality of providing radiotherapy, chemotherapy and targeted treatments and adapt your service appropriately
- Liaise with your radiology colleagues regarding potential suspension of breast screening (following national advice) and post cancer surveillance mammography

Clearly there is a hierarchy of need, and how many of these measures need to be implemented will be dependent upon how severe the pandemic is and what the local capacity is. Please keep up to date with both local and national advice.

The above guidance has been agreed with Andreas Makris, Chair of the UKBCG, and David Miles and has received the full endorsement of the UKBCG.

Kind regards

A handwritten signature in black ink that reads "Julie C Doughty". The signature is written in a cursive style with a large initial 'J' and a distinct 'C' before the surname.

Julie Doughty
President
Association of Breast Surgery

Version 2
Amended 26th March 2020