Breast cancer five-year survival rates are high for people whose cancer is detected early. They are among the highest five-year survival rates.

Advances in treatment over recent years have reduced psychological and physical morbidity (e.g. through the use of sentinel lymph node biopsy, and breast-conserving surgery versus radical mastectomy) and reduced the risk of recurrence and mortality (e.g. through the use of adjuvant chemotherapy, aromatase inhibitors, tamoxifen and surgical removal of ovaries). Genetic profiling advances may help to further increase the effectiveness of treatment and reduce late effects from treatment.

Follow-up includes scheduling regular reviews and ensuring cancer survivors are aware of the risks of late effects associated with their breast cancer treatment.

Five- and 10-year survival (Australia)

In 2004, five-year survival for women with breast cancer was 87.7% and 10-year survival was 79.4%.

Potential issues for survivors

Survivors may experience many different issues after completing treatment: physical, emotional, psychosocial and practical. Survivorship care ideally addresses all of these issues. The four main aims of care during the survivorship phase, as detailed by the Institute of Medicine’s report (see Hewitt et al. 2006) ‘From cancer patient to cancer survivor: lost in transition’, are:

- surveillance for cancer spread, recurrence or second primary cancers
- coordination between specialists and primary care providers to ensure that all of the survivor’s health needs are met (incl. health promotion, immunisation, screening for cancer and non-cancerous conditions, and the care of concurrent conditions)
- intervention for consequences of cancer and its treatment (e.g. problems such as lymphoedema and sexual
dysfunction, symptoms including pain and fatigue, psychological distress experienced by cancer survivors and their caregivers, and concerns related to employment and insurance.

- prevention and detection of new cancers and recurrent cancer.

**Surveillance for cancer spread, recurrence or second primary cancers**

Most recurrences are detected in the five years after diagnosis, although recurrence can occur more than 20 years after the initial diagnosis.

For women who have had mastectomy, the majority of recurrences will be detected by clinical examination alone. For women who have had breast-conserving surgery, a significant proportion will be detected by regular mammography.

**Which patients?**

All patients who have been treated for breast cancer should be followed up.

There is no evidence that follow-up more frequent than the minimal review schedule confers any survival benefit or increase in quality of life.

**New symptoms: advice for survivors**

Cancer survivors may wait to discuss some symptoms if they know a surveillance/follow-up appointment is scheduled. Advise the cancer survivor to contact their doctor if they notice a breast change or any other symptom that concerns them between follow-up appointments.

Advise the cancer survivor you are treating to contact you if they experience:

- unexplained persistent changes in general condition (loss of weight, loss of appetite, loss of energy)
- persistent unexplained pain or discomfort.

**Coordination between specialists and primary care providers**

Follow-up may be performed by the specialist or GP. Follow-up by GPs has not been shown to be associated with increase in time to diagnosis, increase in anxiety or deterioration in health-related quality of life.

It is important that follow-up is coordinated and that survivors are not required to attend excessive appointments.

Guidelines included in the Victorian Government’s patient management framework (breast tumour stream) recommend that follow-up should be by a multidisciplinary team, although not all disciplines need to be involved in the longer term follow-up.

The guidelines recommend that the team, in consultation with the GP, decides on who will coordinate follow-up. Responsibility needs to be agreed between the designated lead clinician, GP and cancer survivor, and an agreed survivorship care plan documented.

The plan should identify who should be notified if the patient does not attend for follow-up.

The GP has a key role in follow-up.

**Follow-up of women with early breast cancer**

<table>
<thead>
<tr>
<th>Method</th>
<th>Years 1 and 2</th>
<th>Years 3–5</th>
<th>After 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>History and examination</td>
<td>Every 3–6 months</td>
<td>Every 6–12 months</td>
<td>Every 12 months</td>
</tr>
<tr>
<td>Mammography of the ipsilateral breast (if breast conserving therapy) and contralateral breast^</td>
<td>Every 12 months*</td>
<td>Every 12 months</td>
<td>Every 12 months</td>
</tr>
<tr>
<td>Chest X-ray</td>
<td></td>
<td>Only if clinically indicated on suspicion of recurrence</td>
<td></td>
</tr>
<tr>
<td>Bone scan, CT, PET or MRI** scans, blood count, biochemistry and tumour markers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

^ Consider ultrasound in addition to mammography for younger women, women with dense breasts and those whose initial breast cancer could not be detected by mammography

* First mammogram 12 months post diagnosis

** Use of MRI may be considered in specific high-risk groups

Source: Adapted from National Breast and Ovarian Cancer Centre (NBOCC) 2010. Follow-up care for women with early breast cancer. A guide for general practitioners. NSW: NBOCC.

Note: this schedule may change, due for example to the detection of recurrence or the development of other illnesses. The schedule needs to be tailored to individual situations. Symptoms should be fully investigated if they arise.
Late effects of breast cancer treatment

Note to cancer survivors: late effects from cancer treatment are generally uncommon and often rare. Do not assume that you will get a late effect if you had a treatment described here. Please speak to your doctor if you have any concerns about late effects from your cancer treatment.

Late effects can occur as a consequence of surgery, chemotherapy, hormone therapy and radiotherapy.

### Late effects of breast cancer treatment

**Fatigue**
- Association with cancer treatment is not clear; may occur in association with depression and anxiety.

**Cardiac toxicity**
- Appears to be dose-dependent
- May appear during or shortly after treatment or months to years after treatment ends
- Anthracycline-containing regimens, trastuzumab (esp. in combination with doxorubicin or epirubicin plus cyclophosphamide), paclitaxel, taxane

**Lymphoedema**
- Surgical axillary dissection or radiotherapy or both

**Premature menopause**
- Chemotherapy, ovarian ablation, tamoxifen, aromatase inhibitors

**Endometrial cancer, stroke, blood clots**
- Tamoxifen

**Depression and anxiety**
- Association with treatment is not well understood

**Pain**
- Surgery, chemotherapy and radiotherapy

**Impaired sexual functioning or sexual discomfort**
- Related to impaired body image due to surgery
- Systemic therapy (esp. chemotherapy) leading to premature menopause/vaginal dryness

**Impaired fertility**
- Chemotherapy
- Ovarian ablation

**Accelerated loss of bone density, fracture risk**
- Ovarian failure following chemotherapy (esp. high-dose corticosteroids, aromatase inhibitors)

**Impaired cognitive functioning**
- Association with treatment is not well understood
- May be associated with adjuvant chemotherapy

**Dissatisfaction with cosmetic result and change in appearance**
- Mastectomy (with or without reconstruction)
- Breast-conserving surgery (smaller effect)

**Second primary cancer**
- May be associated with the individual’s underlying predisposition (e.g. BRCA mutation) and therefore not a late effect of treatment

**Further information related to late effects**
- Women who have received treatment known to increase the risk of cardiac toxicity should receive long-term periodic evaluation of cardiac function as well as advice about other cardiovascular risk factors (e.g. smoking, alcohol, lack of exercise, poor diet).
- Remind survivors of the need to avoid injury to the upper limb and to be alert for any arm changes, to help to reduce the risk of lymphoedema. Lymphoedema may occur years after treatment.
- Women and their families with BRCA mutations may be referred to a familial cancer clinic for advice about prevention and screening.
- Younger women have particular needs if affected by menopause, if they require contraception, and in coping with changes to sexual function. Refer to fertility and menopause specialists and sex therapists who understand cancer care among younger patients if appropriate.
- Depression, anaemia, pain and hypothyroidism can all contribute to fatigue and can be treated. It should be noted that some SSRIs (e.g. paroxetine, fluoxetine) can decrease the efficacy of tamoxifen so other antidepressants should be considered. Venlafaxine has no or minimal effect on tamoxifen metabolism and has also been shown to be an effective intervention for hot flushes.
- Women at risk of accelerated reduction of bone mineral density due to chemotherapy should have their BMD checked every two to four years. Advise about bone density loss prevention such as weight-bearing exercise and smoking cessation. Consider preventive treatment with calcium and vitamin D supplementation, and bisphosphonates for women with osteoporosis, fractures or high rates of bone loss.
- Enquire about mood and whether the survivor feels they are coping. Assess survivor’s level of distress/depression. Psychological distress generally declines over time. Psychosocial interventions (e.g. support group, cancer education) may be effective for women. Support groups and/or contact with a fellow survivor through a service such as Cancer Connect (contact via the Cancer Council Helpline on 13 11 20) may be helpful.
Follow-up of breast cancer survivors

Prevention and detection of new cancers and recurrent cancer

Follow-up care should include counselling about improved diet, maintaining a healthy weight, smoking cessation and increasing physical activity as these may help to prevent secondary, recurrent or a new primary breast cancer. They may also reduce many of the psychosocial consequences of cancer treatment.

Advise survivors (unless there are health reasons that indicate otherwise) to do at least 30 minutes of moderate-intensity physical activity on most, preferably all, days. The NHMRC has produced dietary guidelines for Australian adults, on which advice to survivors can be based.

Survivors need appropriate screening for other cancers at recommended time intervals. All women who have ever been sexually active should commence having Pap tests between the ages of 18 and 20 years, or 1 to 2 years after commencing sexual activity, whichever is later. In some cases screening for cervical cancer may be appropriate before 18 years of age. Women over 70 years of age who have had two normal Pap tests in the past five years do not require further Pap tests. If a woman over 70 years has never had a Pap test, or requests a Pap test, they should be screened. Patients over 50 years should be counselled regarding screening for bowel cancer. There is insufficient evidence for population-based screening for ovarian cancer; however, women who are at potentially high risk should be referred to a familial cancer clinic for assessment and management. Survivors have mammography as part of their follow-up and do not need to respond to invitations from the Australian Government’s breast cancer screening program (BreastScreen).

Don’t neglect other aspects of primary health care. Where indicated, monitor survivors’ cholesterol, blood pressure and blood glucose. Survivors should have regular dental examinations and be counselled on routine sun protection.

Further information

This overview was prepared with reference to:
- NBOCC survivorship website.

Also see:
- National Comprehensive Cancer Network. This US site provides consensus-based guidelines developed by expert groups, and other clinical resources.

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