Impact of Collaborative Evidence-Based Breast Cancer Survivorship Care Guidelines on Survivors and Providers

Erin Hartnett, DNP, APRN-BC, CPNP

Breast cancer survivors face many challenges stemming from both their disease and its treatment. In December 2015, the American Cancer Society and the American Society of Clinical Oncology released collaborative evidence-based breast cancer survivorship care guidelines for female breast cancer survivors and their primary care providers. This article discusses these recommendations for surveillance, screening, and management of both long-term and late effects of breast cancer and treatment.

At a Glance
- The American Cancer Society and the American Society of Clinical Oncology (ASCO) collaborative breast cancer survivorship care guidelines are based on previous recommendations from ASCO and the National Comprehensive Cancer Network.
- These guidelines contain holistic recommendations to help with the surveillance and management of both long-term and late effects of breast cancer and treatment.
- Nurses need to provide information, education, and support to assist women with following these guidelines after treatment for breast cancer.

M any of the 3.1 million breast cancer survivors in the United States (American Cancer Society [ACS], 2014; Siegel, Miller, & Jemal, 2015) face challenges related to both their cancer and its treatment, and they require follow-up care. In December 2015, the ACS and the American Society of Clinical Oncology (ASCO) released collaborative evidence-based breast cancer survivorship care guidelines for female breast cancer survivors and their primary care providers (PCPs) (Runowicz et al., 2016). These guidelines, based on previous recommendations from ASCO and the National Comprehensive Cancer Network, contain holistic recommenda-

Surveillance for Breast Cancer Recurrence or New Primary Cancer

Recommendations include a physical examination every 3–6 months for the first three years after primary therapy, followed by every 6–12 months for the next two years and then annually (Runowicz et al., 2016). Annual mammograms are the only required testing. For women with unilateral mastectomy, annual mammography on the intact breast is recommended, whereas annual mammography of both breasts is recommended for those with lumpectomies (Runowicz et al., 2016). Advanced imaging and routine laboratory testing with tumor markers is not recommended (Henry et al., 2014). Providers must educate patients to be aware of any breast or chest wall changes (e.g., rash, skin changes, pain) that may indicate local or regional recurrence, and survivors should be encouraged to continue anti-estrogen therapy as prescribed by their oncologist. This therapy, which may continue for 5–10 years, has demonstrated reduced risk of recurrence of secondary breast cancers and improved overall survival for estrogen receptor-positive breast cancers (Runowicz et al., 2016). PCPs also should review family history at frequent intervals; any new cancers in the family may increase the survivor’s risk profile. Genetic counseling should be suggested if potential hereditary risk factors are suspected (Runowicz et al., 2016).
Secondary Cancer Screening

The new ACS/ASCO guidelines recommend that PCPs follow the ACS screening guidelines for cervical, colorectal, endometrial, and lung cancers when screening breast cancer survivors, just as they would when screening the general population (ACS, 2015); guidelines for the early detection of cancer are available online from ACS (http://bit.ly/1bxksKS). The new ACS/ASCO guidelines recommend that postmenopausal women taking selective estrogen receptor modulator therapies should have an annual gynecologic examination (Runowicz et al., 2016).

Assessment and Management

Patients need to be informed of the Women’s Health and Cancer Rights Act, which states that insurance benefits after mastectomy must cover reconstruction, external prostheses, and possible physical complications, such as lymphedema. Lymphedema is swelling in the arm, breast, or chest wall that can occur in any breast cancer survivor who has had surgery or radiation to the axilla; it can be either a long-term or late effect. The incidence of lymphedema is estimated to be 40% (Armer & Stewart, 2010). Education, awareness, prevention, and referral to lymphedema specialists, if necessary, are recommended (Runowicz et al., 2016). Referring survivors who are having cognitive difficulties, depression, anxiety, or sexual problems to mental health specialists is also recommended (Runowicz et al., 2016).

Radiation therapy, chemotherapy, and hormone therapy with aromatase inhibitors have been associated with increased risk of cardiovascular disease in survivors (Darby et al., 2015). Educating patients about lifestyle modifications (e.g., smoking, diet, exercise) is important. Postmenopausal breast cancer survivors on an aromatase inhibitor are at increased risk for osteoporosis and should have a baseline dual-energy x-ray absorptiometry every two years. Education on prevention and reduction of bone loss includes doing physical activity and weight-bearing exercise, avoiding tobacco, limiting alcohol, and supplementing with calcium and vitamin D. Bisphosphonates and denosumab (Xgeva®) may be used to prevent bone loss or treat osteoporosis (Runowicz et al., 2016).

Infertility is an issue for many breast cancer survivors. About 10% of patients with breast cancer are aged 20–45 years (National Cancer Institute, 2015). Premenopausal women who are having difficulty conceiving for six months or more should be referred to a fertility specialist (Runowicz et al., 2016).

Health Promotion and Care Coordination

Breast cancer survivors need information on ways to promote healthy behaviors, such as maintaining a healthy weight, eating a low-fat diet, limiting alcohol, avoiding smoking, and engaging in 150 minutes of moderate exercise or 75 minutes of vigorous exercise per week, along with strength training two days per week (Runowicz et al., 2016).

Although no specific guidelines for care coordination exist, providers must collaborate when providing care to breast cancer survivors. Whether patients continue to see the oncology team or transition to primary care depends on many factors, such as the location of healthcare providers, insurance coverage, and other medical needs of the patient. Some patients return to their PCP immediately after treatment, whereas others continue to see their oncologist as well. The shared care model—in which patients are seen by their oncologist for follow-up breast cancer surveillance and continue with their PCP for health maintenance—is preferred.

Conclusion

Implementation of the new ACS/ASCO guidelines requires nurses to be knowledgeable about the long-term and late effects of breast cancer treatment, as well as the recommendations for surveillance for breast cancer recurrence or new primary cancer, screening for secondary cancers, assessment and management of physical and psychological effects, health promotion, and care coordination. Nurses need to provide information, education, and support to assist women with following these guidelines after treatment for breast cancer. In addition, they also must develop interprofessional and collaborative relationships to assist women in receiving necessary follow-up care.

References


FIGURE 1. American Cancer Society and American Society of Clinical Oncology Survivorship Recommendations

Note. Based on information from Runowicz et al., 2016.