

Breast cancer survivorship:

key issues and priorities of care

INTRODUCTION

Breast cancer is the most common malignancy in women in the UK, with an average lifetime risk of 1 in 8. Although the incidence of the disease has risen by 6% over the last 10 years, mortality rates have steadily fallen, and currently 80% of patients with early breast cancer have a projected survival of >10 years.¹ As a result, the number of patients living beyond a breast cancer diagnosis has steadily grown; there were estimated to be 500 000 breast cancer 'survivors' in the UK in 2010 but this number is expected to reach 2 million by 2040.² Once surgery and any chemotherapy and/or radiotherapy treatments are complete, the traditional model of breast cancer follow-up of multiple routine hospital visits has largely been superseded by an 'open access' structure, focusing on supporting self-management and patient empowerment. To make such a service successful, it is suggested that each patient should receive a Recovery Package,³ consisting of the following components:

1. Cancer care review: review by a primary care practitioner within 6 months of a cancer diagnosis to ensure patients know what services are available to them, embedding the principles of self-management at an early stage.
2. End of treatment summary: outlines treatments completed and priorities for future care, including any planned surveillance (for example, annual mammograms) and advice on symptoms and signs that could indicate recurrence;
3. Health needs assessment: comprehensive questionnaire completed by the patient, including a concerns checklist, distress thermometer, and care plan;
4. Health and wellbeing events: group events that provide an opportunity for patients to be educated on issues such as how to maintain a healthy lifestyle and management of long-term consequences of cancer treatment.

These measures should enable rapid and appropriate self-management or self-referral back to a hospital breast unit, but it is also important that GPs are aware of the common problems and concerns affecting this population.

MENOPAUSAL SYMPTOMS

Many breast cancer treatments can induce menopausal symptoms that may be more severe than those of the physiological menopause, and significantly affect quality of life. A variety of approaches can be attempted including acupuncture, cognitive behavioural therapy, antidepressants, and gabapentin. Hormonal replacement therapy should be avoided in women with a history of early breast cancer because this may precipitate recurrence. Urogenital symptoms including atrophic vaginitis can be a particular problem with aromatase inhibitor therapy. Lifestyle modifications may help, such as stopping smoking and avoiding scented hygiene products. Vaginal non-hormonal preparations may also be helpful, but topical oestrogen preparations are best avoided if possible owing to the potential for systemic absorption. Occasionally, menopausal symptoms are so troublesome that women wish to stop their endocrine therapy; in these cases, discussion with the patient's oncologist as to the risk-benefit trade-off is usually indicated.

BONE HEALTH

Women treated for early breast cancer, particularly those on adjuvant hormone therapies, are at significant risk of osteoporosis and its associated complications. In patients who are pre-menopausal, tamoxifen appears to accelerate annual bone loss by 1–2% only, and therefore these patients do not routinely require bone monitoring or protection. By contrast, aromatase inhibitors (such as letrozole, anastrozole, and exemestane) significantly increase the risk of osteoporosis and associated fracture.^{4,5} Patients receiving these agents should have a calcium-rich

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Provenance

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diet, take 1000–2000 IU vitamin D daily and undertake regular weight-bearing exercise. For those with a baseline T score of <2, assessment of bone mineral density should be undertaken every 1–2 years. In the event of >10% loss annually, or 4–5% if the patient was osteopenic at baseline, an oral or intravenous bisphosphonate should be initiated.⁶

PSYCHOLOGICAL

There is no standard psychological reaction to a diagnosis of breast cancer, and patients vary in their ability and methods of coping. They may struggle with uncertainty, particularly in relation to future recurrence, family and relationship stress, disordered mood including anxiety and depression, and issues around body image. Effective patient-centred communication and a continued focus on supportive self-management are key to detecting and preventing potential psychological problems. In difficult cases, referral for counselling or cognitive behavioural therapy may be helpful.

Some patients report cognitive problems during the time of chemotherapy, including difficulties with word-finding, multitasking, short-term memory, and attention span, and in some cases these persist beyond treatment completion. There is evidence that non-pharmacological intervention, such as cognitive training, exercise, yoga, and mindfulness-based activities, may be helpful in some patients.

FATIGUE

Cancer-related fatigue is poorly understood, but has been reported in 30–50% of breast cancer survivors in the first 5 years after treatment.⁷ Significant risk factors include chemotherapy and coexistent depression, anxiety, or catastrophising personality, and identifying these at-risk patients early may be helpful. Management may include promotion of physical activity and exercise, acupuncture, cognitive-behavioural interventions, and mind-body interventions such as yoga and massage. Guarana and ginseng may be helpful, but this has not been confirmed in randomised clinical trials.

LOCAL AND REGIONAL CHANGES

Changes in the breast tissue are common in patients who have undergone surgery and adjuvant radiotherapy; these can include breast shrinkage, telangiectasia, pigmentation, and breast swelling. Patients are counselled regarding these changes prior to therapy, but they can nonetheless cause concern, and if there is uncertainty as to the significance of clinical findings, patients should be reassessed at their breast unit.

Breast-cancer-associated lymphoedema is three times more common in patients who have undergone axillary dissection compared with those who had sentinel lymph node biopsy only. Those who have had more nodes removed, mastectomy, or who are overweight are also at higher risk.⁸ Post-surgery, patients are given advice on how to prevent and treat symptoms, which includes manual lymphatic drainage, compression therapy (sleeves or bandages), and good skin care. All patients should be advised to avoid trauma and venepuncture to the affected arm, to obtain antibiotics promptly if infection develops, and to maintain a healthy body weight.

LONG-TERM IMPLICATIONS OF BREAST CANCER TREATMENT

These include chemotherapy-induced infertility and, in patients who remain fertile, the timing of future pregnancies. Patients may seek advice regarding their options and are likely to merit re-referral to secondary care, as a complex risk-benefit analysis is likely to be involved.

A number of interventions used to treat early breast cancer (anthracycline chemotherapy, radiotherapy, and trastuzumab) increase the risks of cardiotoxicity. This will usually be detected during the active phases of treatment; however, some patients, particularly those with pre-existing risk factors for cardiac disease, may remain at increased risk of cardiac complications (particularly left ventricular failure) in the longer term.

Patients who have treatment for early breast cancer remain not only at risk of recurrence of their breast cancer (at local or metastatic sites) but are also at increased risk of other primary malignancies as a result of the treatment they have received. These include tamoxifen-associated endometrial cancer, radiotherapy-associated lung cancer, and an increased risk of haematological malignancies (myelodysplastic syndrome and acute myeloid leukaemia) owing to chemotherapy exposure.

CONCLUSION

There are clearly many potential implications that a diagnosis and treatment of early breast cancer might have on a patient that may lead them to seek advice and guidance from their primary care physician. Many GPs feel comfortable dealing with these issues, but, where this is not the case, clear communication between breast cancer units and primary care will be essential for the safe and effective care of this large and ever-increasing population of women.