



Clinical guidelines: breast cancer



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Case histories are based on actual medical negligence claims, however, certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.

Failure to diagnose breast cancer is a relatively common cause of complaints and claims involving general practitioners. This article examines the use of evidence based clinical guidelines and outlines some risk management strategies for GPs to minimise the possibility of a complaint or claim arising from an allegation of failure to diagnose breast cancer.

Case history

On 24 October 2003, Mrs Fiona Barnes presented to her general practitioner complaining of a tender lump in her left breast. The patient, 50 years of age, had recently commenced hormone therapy (HT) for the short term management of menopause symptoms. Mrs Barnes had noticed some bilateral breast tenderness since commencing HT. The GP obtained a history of a gradual increase in size of the breast lump over the past 2 months. There was no past history of breast problems and no family history of breast cancer. A screening mammogram performed 6 months earlier had been reported as normal. On examination, the GP found a 3 cm smooth, tender, mobile lump in the lower outer quadrant of the left breast. There was no palpable axillary lymphadenopathy. The GP advised the patient that the breast lump was probably a cyst. She referred the patient to a local radiology practice for a mammogram and ultrasound of the lesion. The GP also requested a fine needle aspiration (FNA) of the presumed cyst with cytology of the fluid. The patient

was asked to return for review after undergoing the radiological investigations. The GP stressed the importance of having another clinical breast examination to ensure that the breast lump had resolved following the FNA.

On 14 November 2003, Mrs Barnes re-attended for review. The mammogram and ultrasound had confirmed the presence of a simple breast cyst. The radiologist had performed a FNA and removed 10 mL of straw coloured fluid. Cytology did not reveal any malignant cells. The GP re-examined the patient's breasts. She noted some tenderness and thickening in the area of the FNA but no discrete lesion. The GP reassured the patient that it appeared the lesion was a benign cyst – most likely associated with the HT. The GP asked Mrs Barnes to return for further review in 3 months.

The patient returned for review on 12 January 2004 complaining of a recurrence of the left breast lump. Clinical examination confirmed the presence of a lump in the area of the previous breast cyst. The GP gave Mrs Barnes a referral to a local breast surgeon for further assessment. One month later, the GP

received a letter from the surgeon stating that he had re-aspirated the breast cyst. He had advised Mrs Barnes to return for review in May to ensure there was no recurrence of the lump. Mrs Barnes saw the GP again on 2 April 2004 because she felt her left breast was 'still not right'. The GP thought she could feel a discrete lump in the left lower quadrant. She phoned the surgeon and arranged an urgent appointment for Mrs Barnes. The surgeon subsequently rang the GP to inform her that he had performed a core biopsy of the area. This had revealed malignant cells. Two weeks later, the patient underwent a left mastectomy and sentinel lymph node mapping and biopsy. This confirmed a low grade unifocal cancer with no axillary lymph node involvement.

Medicolegal issues

The general practitioner saw Mrs Barnes soon after her discharge from hospital. The patient said she was extremely grateful that the GP had followed up her breast symptoms so carefully. However, Mrs Barnes was concerned that both the radiologist and pathologist must have 'misdiagnosed' the tests. She also complained that the surgeon should have diagnosed her breast cancer earlier. Mrs Barnes said that she had done some 'internet research'. She thought the surgeon should have performed a biopsy in February 2004. The GP discussed the patient's concerns with her and outlined the diagnostic process of investigating a breast lump. At the conclusion of the discussion, the GP offered to contact both the radiologist and pathologist and ask them to review the investigations. Mrs Barnes said she would do some more internet research and that she intended to discuss her concerns with the surgeon at her postoperative visit. Following contact from the GP, both the radiologist and pathologist wrote to the patient and GP. The letters confirmed that a review of the investigations had not revealed any errors in reporting. At a further visit, the patient told the GP that she had discussed her concerns with the surgeon and was very satisfied with his response. She was also pleased that both the radiologist and pathologist had taken the trouble to respond to her concerns. All in all, she was 'very happy to have received such expert care from everyone'.

Discussion

Breast cancer is the most common cause of cancer related death in women in Australia. One in 11 women will be diagnosed with breast cancer before the age of 75 years. The risk of breast cancer increases with age. Of new breast cancer cases diagnosed in 2000:

- 25% were in women aged 20–49 years
- 48% in women 50–69 years, and
- 27% were in women aged 70 years and over.¹

In this case, the patient initially complained

that she thought the diagnosis of breast cancer had been delayed. However, on review, it was apparent that all the practitioners involved in her care had acted in accordance with a reasonable standard of care. Indeed, the GP was able to demonstrate to Mrs Barnes that the care she had received was in accordance with current clinical guidelines, as outlined in the National Breast Cancer Centre (NBCC) guide *The investigation of a new breast symptom*.¹ The triple test, comprising clinical breast examination, mammography and fine needle aspiration (FNA) cytology, has a true positive rate of 99.6%. Therefore, in approximately one in 250 women a diagnosis of breast cancer will be missed by the triple test. Thus, a small proportion of breast cancer cases will not be correctly identified, even when all the recommended investigations are performed.

Over the past decade, clinical guidelines have become an increasingly familiar part of medical practice. Clinical guidelines can be defined as 'systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances'.² The use of evidence based clinical guidelines can improve patient care and health outcomes. They can also be used to demonstrate that an individual practitioner's care met the standard expected of a reasonable practitioner. Following guidelines that are relevant to a patient's condition may provide support in the event of a subsequent complaint or claim alleging negligence.

Risk management strategies

The NHMRC National Breast Cancer Centre and The Royal Australian College of General Practitioners have developed a guide for GPs *The investigation of a new breast symptom*.¹ The aim of this guide is to maximise the effectiveness of the investigation of women who present to their GP seeking medical advice with a new breast symptom. The triple test (clinical breast examination, mammography and FNA cytology) is recommended for the investigation of any

breast lump. Patients presenting with a breast lump need to be advised of the need to complete all the components of the triple test and to attend for appropriate follow up.

The NBCC guide notes that breast cysts account for approximately 15% of all discrete breast masses, particularly in perimenopausal women and may present in women taking HT. Cysts are readily diagnosed on ultrasound. Management of breast cysts include:

- FNA is recommended if the cyst is symptomatic, ie. easily palpable and/or painful
- the fluid can be discarded provided it is not bloodstained or mucoid
- if the ultrasound features are not typical of a simple cyst, FNA under ultrasound +/- cytology is recommended
- after aspiration, the breast must be re-examined to check that the palpable mass has disappeared
- any residual mass requires cytology and full assessment, and
- rapid or persistent recurrence of a cyst requires further investigation.¹

Summary of important points

- Follow up patients with breast symptoms and/or signs to a definitive diagnosis or resolution of the symptoms and signs.
- Adopt and follow the National Breast Cancer Centre guidelines for the investigation of a new breast symptom.

Conflict of interest: none.

References

1. National Breast Cancer Centre. *The investigation of a new breast symptom. A guide for general practitioners*, 1997. Available at: www.nbcc.org.au/bestpractice/.
2. Woolf SH, Grol R, Hutchison A, et al. Potential benefits, limitations and harm of clinical guidelines. *BMJ* 1999;318:527–530.

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