Breast cancer

Guiding your patient through treatment

Meagan Brennan
BMed, FRACGP, DFM, FASBP, is a breast physician, NSW Breast Cancer Institute, Westmead Hospital, New South Wales. meaganb@bci.org.au

Elisabeth Black
DipAppSc(Nurs), BN(Midwifery), PGDipNursSc(breast care), is a specialist breast care nurse, NSW Breast Cancer Institute, Westmead Hospital, New South Wales.

James French
MBBS, FRACS, is a breast and endocrine surgeon, NSW Breast Cancer Institute, Westmead Hospital, New South Wales.

John Boyages
MBBS, FRANZCR, PhD, is Associate Professor and Executive Director, NSW Breast Cancer Institute, Westmead Hospital, New South Wales.

This twelfth article in our series on breast disease provides practical advice on overcoming obstacles faced by both the woman and her general practitioner on the diagnosis of breast cancer.

Facing treatment for breast cancer can be difficult for both the woman and her general practitioner. While the patient clearly has many issues to confront, there are also many difficulties faced by the GP such as breaking bad news, finding a treatment team, managing the side effects of treatment, and providing information and support for the patient and her family.

Breaking bad news

Telling a woman she may have breast cancer is never easy. Breaking bad news requires time, patience, sensitivity and compassion. Women with breast cancer, when surveyed, reported a preference for communication styles that:

- acknowledge the emotional aspects of breast cancer and its treatment
- convey messages in a positive but accurate fashion
- convey friendly interest in the woman as a person, and
- cultivate a positive attitude.[1]

Some recommended communication skills are listed in *Table 1*. These communications skills may be required, not just at diagnosis, but at many stages along the breast cancer journey. Sensitivity must be used at other times, for example discussing treatment options that may lead to the woman losing her breast; discussing pathology results which may mean further surgery or more aggressive adjuvant treatment is required; and when dealing with side effects of treatment.

Finding a breast cancer treatment team

It is now generally accepted that a multidisciplinary approach to care is needed for treating women with breast cancer. There are many models of such care, but all emphasise the need for clinicians from a range of specialties such as surgery, radiation oncology, medical oncology, imaging and pathology, to work together to develop and carry out a treatment plan for the patient. The referring GP, as the clinician who is a constant, is a critical member of the team. The GP also usually knows the patient on a more personal level and is therefore able to determine the style of treatment most likely to suit the patient's needs.

Multidisciplinary breast cancer treatment teams can be found at most teaching hospitals and many private facilities. Many smaller and rural hospitals also provide such care, often with links to teaching hospitals to refer or obtain advice on the management of particularly challenging cases. A Directory of Breast Cancer Treatment and Services is available online at www.bci.org.au. This directory lists surgeons, radiation oncologists and medical oncologists across Australia. It provides information on where they practise and the type of treatment they offer including case conferencing and participation in team based management.

Specialist breast care nurses

Most multidisciplinary breast cancer teams include a specialist breast care nurse (SBCN) – a registered nurse with specialised training in all issues related to breast cancer treatment and support. The role of the SBCN is to apply advanced knowledge of the health needs, preferences and circumstances of women with breast cancer to optimise the woman's health and wellbeing at the different stages of care. This includes support during diagnosis, treatment, rehabilitation, follow up, and palliative care. The importance of the SBCN has recently been formally recognised and there is now a well developed professional pathway for nurses undertaking postgraduate study in breast cancer nursing.[2] A 2000 report by the National Breast Cancer Centre found that women with breast cancer greatly value the support of a SBCN. The SBCN is in a unique position within the multidisciplinary team setting to offer information, and

emotional and practical support at times when it is most needed[3] and is usually easily available to patients and GPs during the early decision making process and later during treatment. This makes the SBCN the ideal person for the GP to contact when problems arise. The SBCN can also contact the treating specialists and arrange urgent review if required.

Information and support

Women with breast cancer require support as well as information. Common psychological issues experienced by women with breast cancer include:

- fear of what the diagnosis means and of the treatment that lies ahead
- issues related to body image and sexuality
- concern about prognosis and what the future holds
- concern about how to talk to family (especially children) and friends/work colleagues about the diagnosis
- concern about other female members of the family such as daughters and sisters whose risk of breast cancer is increased by the patient's diagnosis.

Some of these issues are prominent at the time of diagnosis and others present at a later stage. It is common for women to be very busy with treatment in the early months and to appear to be coping without any problems. When treatment is over and the support of the medical and nursing team is no longer there on a daily or weekly basis, many women struggle as they try to return to a 'normal life'. The first annual check and mammogram after the diagnosis is a time when extra support may be needed as issues related to the 'anniversary' are experienced.

Support and information about breast cancer for patients and doctors can be obtained from a number of sources (*Table 2*). These include treatment guidelines for clinicians as well as information brochures and support services for patients.

Table 1. Communication skills to use when breaking bad news[1]

- Express empathy and listen effectively
- Avoid medical jargon and explain difficult terms
- Use explicit categorisation
- Actively encourage questions
- Actively seek understanding
- Repeat important information
- Summarise important information
- Write down relevant information
- Tape the consultation as needed and if wanted
- Send a summary letter as follow up

Table 2. Sources of breast cancer information and support

- The breast cancer treatment team and specialist breast care nurse
- National Breast Cancer Centre at www.nbcc.org.au
  - provides guideline's for clinicians and information for patients about a range of breast cancer issues such as: early breast cancer, advanced/metastatic breast cancer, ductal carcinoma in situ, family history of breast cancer, multidisciplinary care, multilingual breast cancer resources
- NSW Breast Cancer Institute at www.bci.org.au
  - provides patient information brochures, Directory of Breast Cancer Treatment and Services, B-Mail, M-Mail and Mates-Mail (email support groups for patients and their partners)
- The Cancer Council at www.cancer.org.au or Helpline 13 11 20
  - produces a range of publications (including a booklet on how to talk to children about cancer) for consumers, offers a peer support program for women and men with breast cancer, provides access to support groups (including telegroup counselling) and telephone advice
- Consumer groups offer information and peer support:
  - Breast Cancer Network Australia provides a 'My journey' kit and 'My care' kit
  - Breast Cancer Action Group NSW at www.bcagnsw.org.au

Side effects of treatment: how to treat and when to worry

Surgery

With the trend toward early discharge after surgery, GPs are becoming more involved in managing pain, surgical drains, and wounds, in the early days following surgery.

Pain

Severe pain following surgery for breast cancer is uncommon. Most patients are comfortable with paracetamol or a paracetamol/codeine preparation by the time they leave hospital. Pain may be worse for patients who have had an immediate breast reconstruction following mastectomy if they have a tissue expander in situ. These patients may experience a feeling of tightness in the wound. Any pain from surgery should improve rapidly over the first week. If the patient complains of increasing pain, consider a wound infection or seroma (see below).

Surgical drains

Drains (*Figure 1*) from a breast wound are usually removed before discharge, but drains in an axillary wound generally need to stay in for longer (typically 7–10 days) and are often still in situ on discharge from hospital. Drains are used in an attempt to decrease the size and incidence of seroma formation. The volume of serous fluid that drains is variable but may be as high as several hundred mLs per day.

Drains are usually managed by a community nursing team in consultation with the hospital surgical team, however there are occasions when the GP will be asked for advice. Common problems with drains are:

- blocked drain: drainage stops and there may be an accumulation of fluid (seroma)

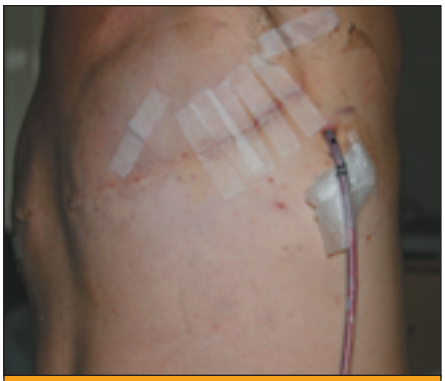

Figure 1. Surgical drain

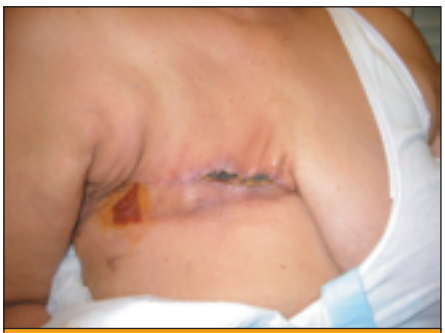

Figure 2. Poorly healing wound edges after a mastectomy

which can be seen or palpated in the axilla or breast. Sometimes the drain can be flushed, but it will often need to be removed once it has become blocked. Any resulting seroma can be aspirated (see below)

- leaking drain: it can be distressing for the patient when fluid leaks from the drain site on the skin. Generally the drain can be left in place and the area dressed with pads. The patient should be reassured this is a common problem that is annoying, but not dangerous.

Wound problems

Wound infection: redness at the wound edges is common and is a part of normal healing. It does not require treatment with antibiotics. True wound infection with swelling, marked erythema, pus, and increasing pain is uncommon. When it occurs, dressings and treatment with oral antibiotics (flucloxacillin or dicloxacillin) and review by the surgeon is indicated.

Seroma formation in the breast or axillary wound is common and occurs in up to 30% of patients following treatment. If there is significant swelling and discomfort the fluid may be aspirated with a needle and syringe. This may need to be repeated several times (every few days) until it settles. Typically this requires two aspirations per week for 2 weeks.

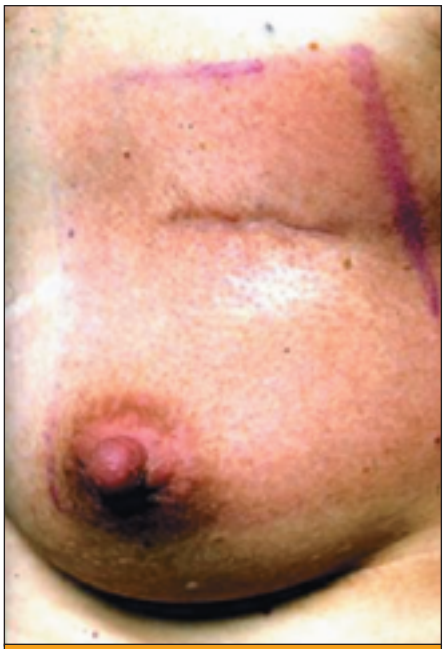

Figure 3. Erythema and dry desquamation after radiation therapy

Poor healing at wound margins may occur, especially in mastectomy wounds when the skin flaps must be made thin to ensure removal of as much breast tissue as possible (*Figure 2*). This poor healing occurs in approximately 1% of mastectomy wounds. The risk is higher in smokers due to damage to the microcirculation in the skin. Treatment is usually either early debridement, if there is enough skin to primarily close, or with dressing.

Shoulder stiffness

Stiffness of the shoulder is a potential complication of axillary surgery. With the advent of sentinel node biopsy, shoulder stiffness is likely to become less of a problem. The patient should be encouraged to start performing shoulder exercises prescribed by the surgeon and physiotherapist early, and to report any stiffness not responding to this program.

Radiotherapy

General practitioners sometimes need to treat skin problems such as dry or moist desquamation (like a sunburn where the dermis is exposed). These conditions are most common during the 5–6 weeks of treatment when the patient is having daily visits to the treating hospital, but they can occur any time within the first 4 weeks of treatment completion.

Common reactions that may occur during treatment include skin reddening and irritation (*Figure 3*). Mild erythema may occur by the second or third week of treatment. The skin tends to become more erythematous toward the end of treatment and settles in the 2 weeks post-treatment. Recommended treatments for skin irritation are outlined in *Table 3*.

Other side effects of radiotherapy include:

- tiredness
- mild to moderate oedema of the breast (worse in the first year post-treatment; slowly improves)
- aches and pains (some discomfort is normal but does not usually require medication)
- hair loss (only occurs to the armpit when the axilla is irradiated)
- sore throat (may occur if the lymph glands at the base of the neck are irradiated)
- radiation pneumonitis (rare; usually presents with a cough, excessive tiredness and requires treatment with corticosteroids and antibiotics).

Chemotherapy

A wide range of chemotherapy regimens is used in the adjuvant setting for breast cancer. Common side effects are nausea and vomiting, myelosupression, and hair loss.

- Myelosupression: during chemotherapy treatment the patient is usually under close observation by the medical oncology team. The main problem for the GP to be alert for is the febrile patient who may be neutropenic. This requires prompt referral for investigation and treatment
- Hair loss is often very distressing for patients. Most hospitals have resources to support patients such as a wig library. The treatment team, SBCN or Cancer Council Helpline can direct patients to their nearest wig library
- Menopause: women who are premenopausal may have treatment induced menopause. Menopause induced

Table 3. Recommended treatments for skin irritation during radiotherapy

- To help prevent skin irritation
  - apply sorbolene, vitamin E, or aloe vera cream once or twice per day
  - wear only 100% cotton clothing
  - avoid perfumed soaps and lotions
  - salt baths or saline sprays are recommended
  - avoid aluminium based deodorant on the treated side (tea-tree oil and rock salt deodorant are useful alternatives)
  - expose irritated skin to the air (but not the sun)
- To treat mild skin irritation and itch
  - sorbolene cream or hydrocortisone 1% cream
- For more significant irritation or moist desquamation
  - Solugel, pawpaw cream, or silver sulphadiazine cream

by chemotherapy is more common in older women (over 40 years of age) than in younger women[4]

- Weight gain is common during breast cancer treatment. It may be distressing for the patient. Advice on nutrition and exercise may be required.

Adjuvant hormonal therapy

Tamoxifen

Tamoxifen is used as adjuvant treatment for women who have hormone receptor positive breast cancer. It is given as a daily oral dose for 5 years. Common side effects include hot flushes, vaginal discharge or dryness, and occasionally weight gain. Often these are not severe enough to require treatment, but if they are causing significant discomfort:

- hot flushes may be treated with the herbal extract black cohosh (Remifemin) or the antidepressant venlafaxine (Efexor)
- vaginal dryness may be treated with lubricants such as Sylk® or a topical oestrogen that is not systemically absorbed such as Vagifem®.

The side effects above also respond very well to oral oestrogen therapy, but hormone therapy is avoided in women who have had previous breast cancer as there is evidence that it increases the risk of recurrence.[5]

More serious side effects of tamoxifen treatment are deep venous thrombosis, pulmonary embolus, and endometrial carcinoma. Any abnormal vaginal bleeding should therefore be promptly investigated in a women taking tamoxifen. Routine ultrasound screening for endometrial change is not recommended.

Aromatase inhibitors

The newer hormone treatments for breast cancer are the aromatase inhibitors (AIs) anastrozole (Arimidex), exemestane (Aromasin) and letrozole (Femara). Aromatase inhibitors are only effective in postmenopausal women with oestrogen receptor positive tumours. They are used widely in metastatic breast cancer. They have also been shown to reduce the risk of recurrence and to improve disease free survival compared to tamoxifen in the adjuvant setting after early breast cancer.[6] Currently their use is restricted to certain Pharmaceutical Benefit Schedule indications, but they are likely to be used more as these restrictions are gradually being lifted. Aromatase inhibitors may also cause hot flushes and vaginal dryness or discharge. They also have the more serious side effects of osteoporosis and cardiac problems. It is recommended that bone density be monitored in women taking AIs.

Other issues

The impact of breast cancer on the family is something the GP is often more aware of than the specialist treatment team. The partner and any children are affected by the diagnosis as are other family members and close friends. Treatment for breast cancer may include surgery, chemotherapy and radiotherapy which typically take about 6 months to complete. This leads to a significant impact on family life for the duration of this treatment. In some families, a diagnosis of breast cancer raises concerns about genetic mutations that may impact the entire family.

When treatment for breast cancer has been completed, the patient continues to require support. Often there is a delayed experience of shock and grieving that occurs after treatment. Issues not fully contemplated because life was so busy may become more important at this point. The challenges in moving on after breast cancer will be covered in more detail in the next article in this series.

Conclusion

Helping a patient through treatment for breast cancer provides challenges for the GP. Finding a treatment team, dealing with the side effects of treatment and finding sources of information and support are required.

Conflict of interest: none.

References

1. iSource National Breast Cancer Centre Early Breast Cancer Working Group. Clinical practice guidelines: management of early breast cancer. Canberra: 2001.
2. National Breast Cancer Centre. Specialist breast nurse competency standards and associated educational requirements. Camperdown: National Breast Cancer Centre, 2005.
3. National Breast Cancer Centre. Specialist breast care nurses: an evidence based model for Australian practice. Camperdown: National Breast Cancer Centre, 2000.
4. Goodwin PJ, Ennis M, Pritchard KI, et al. Risk of menopause during the first year after breast cancer diagnosis. J Clin Oncol 1999;17:2365–70.
5. Holmberg L, Anderson H, HABITS steering and data monitoring committees. HABITS (hormonal replacement therapy after breast cancer: is it safe?) a randomised comparison: trial stopped. Lancet 2004;363:453–5.
6. Winer EP, Hudis C, Burstein HJ, et al. American society of clinical oncology technology assessment on the use of aromatase inhibitors as adjuvant therapy for postmenopausal women with hormone receptor positive breast cancer: status report 2004. J Clin Oncol 2005;23:1–11

afp CORRESPONDENCE email: afp@racgp.org.au