North of Scotland Clinical Management Guideline (CMG): Breast Cancer Surgery Guideline

Last Updated 12/11/2020

Document Control

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General Principles

- This document has been developed to accompany the NoS Breast Cancer CMG with a focus on breast cancer surgery.
- This document is a guideline to breast cancer surgery, patients must be involved in all decision-making relating to their care with informed consent required for patients undergoing treatment.

For symptoms of suspected Breast Cancer, please refer to the Scottish Referral Guidelines for Suspected Cancer

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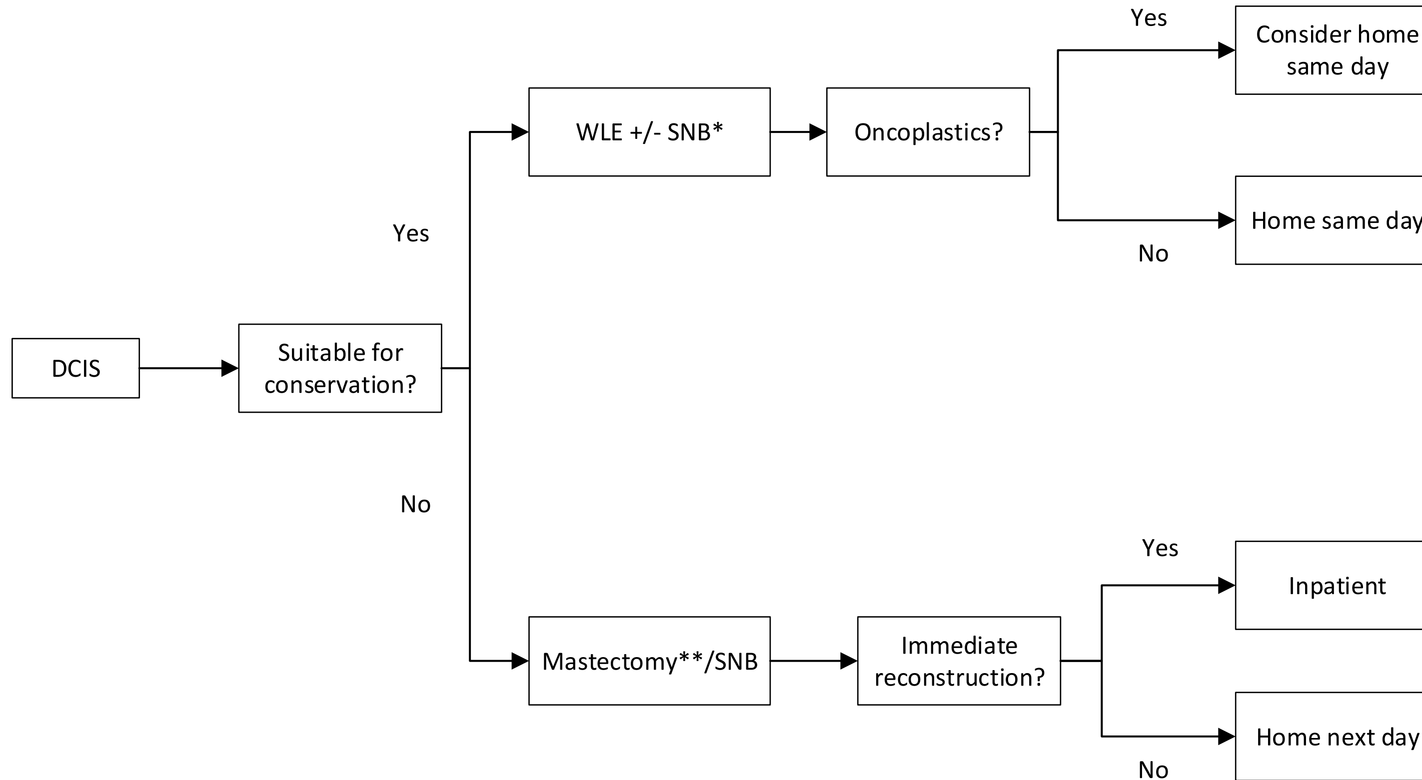
Definitions

DCIS	Ductal Carcinoma In Situ
FNA	Fine Needle Aspiration
MDT	Multi-disciplinary Team
SLNB	Sentinel Lymph Node Biopsy
U/S	Ultrasound
VAB	Vacuum Assisted Biopsy
FNA	Fine Needle Aspiration
WLE	Wide Local Excision
NoS	North of Scotland
CMG	Clinical Management Guideline
+ve	Positive
-ve	Negative

B3 Lesions and Lobular In Situ Neoplasia

Guidance on the Management of B3 Lesions			
Lesion diagnosed on 14g or vacuum-assisted biopsy (VAB)	**Risk of upgrade**	**Recommended Investigation**	**Suggested approach for follow-up if no malignancy on VAE – awaiting further evidence review**
Atypical intraductal epithelial proliferation (AIDEP)	18-87% with 14g; pooled value 21% after VAB	Excise/sample thoroughly with VAE, in general equivalent to approx. 4g (12 x 7g cores). If larger area of microcalcification, consider sampling more than one area. Consider histological diagnosis in light of all biopsies.	Surveillance Mammography. [The optimal frequency and length of surveillance mammography for these lesions is unclear and awaits further guidance. At present many units are undertaking annual mammography for 5 years.]
Classical (not pleomorphic) lobular neoplasia	Pooled value 27%	Excise/sample thoroughly with VAE, in general equivalent to approx. 4g (12 x 7g cores), even if lesion thought to be coincidental.	
Flat epithelial atypia	13-21% (in pure form); may co-exist with AIDEP +/- LN and risk then higher	Excise/sample thoroughly with VAE, in general equivalent to approx. 4g (12 x 7g cores). If larger area of microcalcification consider sampling more than one area.	
Radial scar **with** epithelial atypia	36%	Excise/sample thoroughly with VAE, in general equivalent to approx. 4g (12 x 7g cores)	
Papillary lesion **with** epithelial atypia	36%	Surgical diagnostic excision (because of need to microscopically measure the atypical area for diagnosis)	
Mucocoele-like lesion with epithelial atypia	21%	Excise/sample thoroughly with VAE, in general equivalent to approx. 4g (12 x 7g cores).	
Radial scar or papillary lesion **without** epithelial atypia	<10%	Excise/sample thoroughly with VAE, in general equivalent to approx. 4g (12 x 7g cores).	Return to NHSBSP. These lesions are not known to be associated with long-term risk of development of carcinoma
Cellular fibroepithelial lesion	37% (range 16-76%) phyllodes tumours, but rarely (<2%) malignant	Surgical excision	
Mucocoele-like lesion **without** epithelial atypia	<5%	Excise/sample thoroughly with VAE, in general equivalent to approx. 4g (12 x 7g cores).	
Miscellaneous others such as some spindled cell lesions, microglandular adenosis adeno-myoepithelioma	Depends on lesion	Diagnostic surgical excision	

Ductal Carcinoma in Situ (DCIS)



*Audit data from NHS Tayside suggest SNB could be considered in patients with 50 microcalifications on imaging, mass effect on ultrasound or palpable abnormality

** Reconstruction can be performed as a delayed procedure after mastectomy

Re-excise if radial margins are <1mm after WLE

Breast irradiation may be required following conservation.

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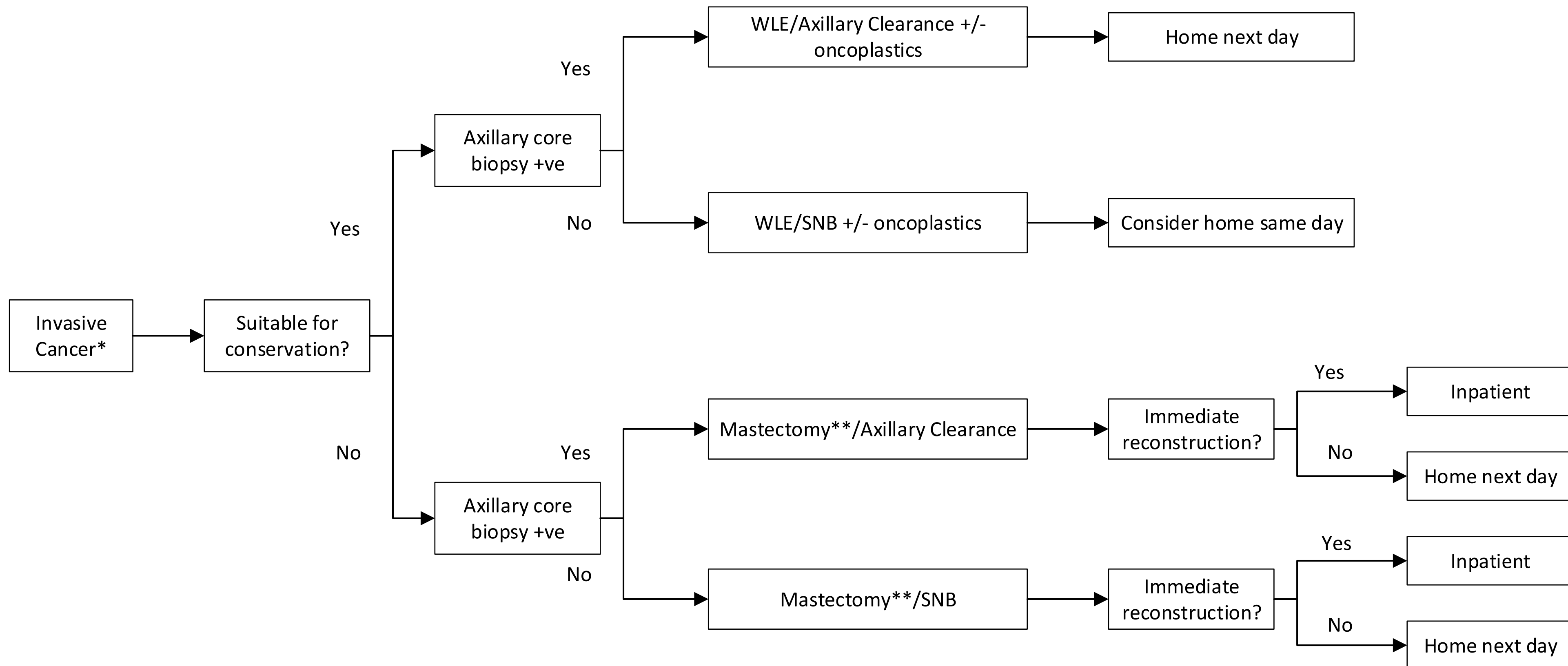
Invasive Cancer

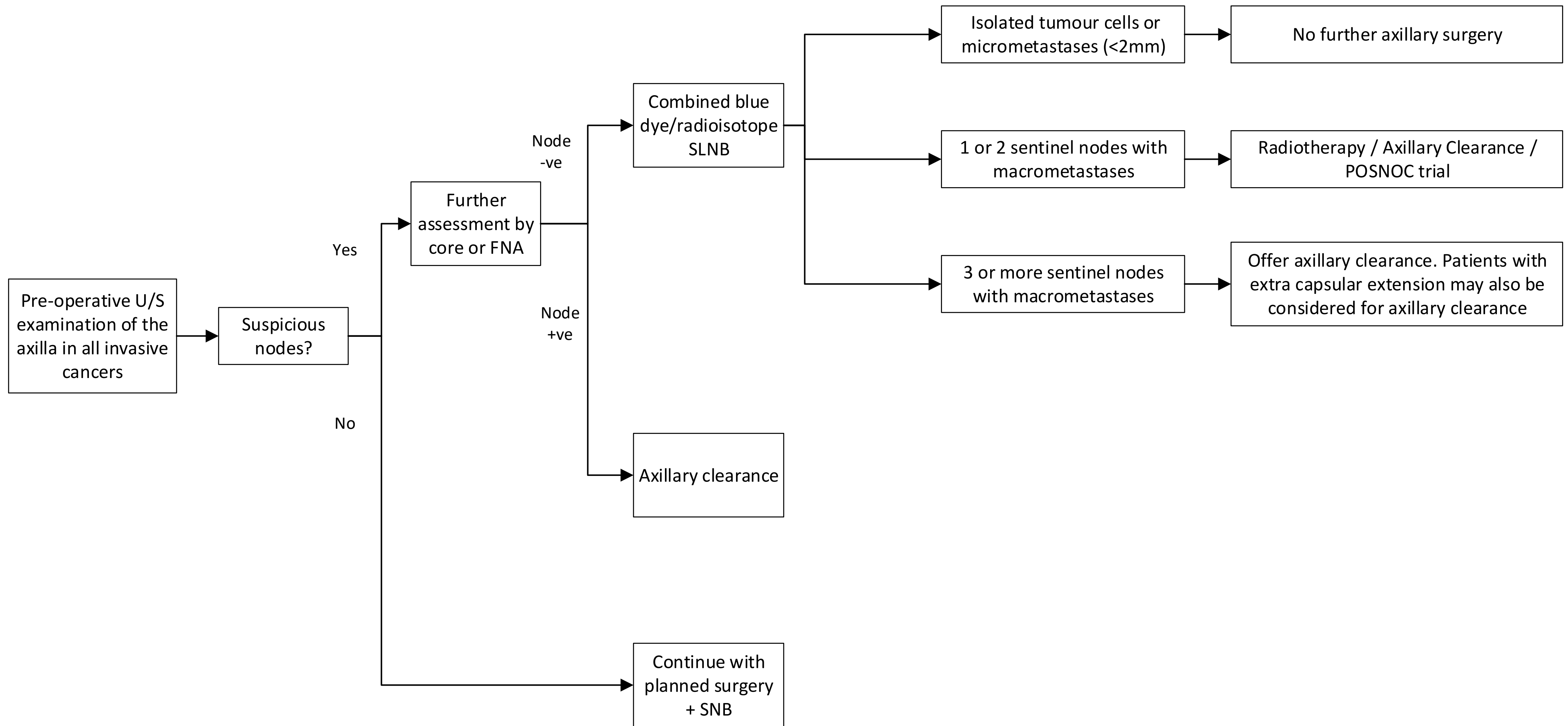


* The choice of surgery must be tailored to the individual patient: the patients should be fully informed of the options made aware that present RCT evidence suggests:

- There is no survival benefit to mastectomy
- Local recurrence rates are slightly higher following breast conservation
- Breast irradiation may be required following conservation.
- Re-excise if radial margins are <1mm after WLE

** Reconstruction can be performed as a delayed procedure after mastectomy

Management of the Axilla



Patients with pre-operative +ve nodes who receive neo-adjuvant chemotherapy may not need axillary clearance