

Advanced breast cancer: diagnosis and treatment

Clinical guideline

Published: 23 February 2009

[nice.org.uk/guidance/cg81](https://www.nice.org.uk/guidance/cg81)

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or service users. The application of the recommendations in this guideline are not mandatory and the guideline does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Local commissioners and/or providers have a responsibility to enable the guideline to be applied when individual health professionals and their patients or service users wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline replaces TA30, TA54 and TA62.

This guideline is the basis of QS12.

Overview

This guideline covers care and support for people with advanced (stage 4) breast cancer. It aims to help them and their healthcare professionals make shared decisions about tests and treatments to improve outcomes and quality of life.

Who is it for?

- Healthcare professionals
- Palliative care services
- People with advanced breast cancer, their families and carers

Introduction

The addendum to NICE clinical guideline 81 has added recommendations on exercise in people with or at risk of breast-cancer-related lymphoedema to [section 1.5](#) of the NICE guideline. The [addendum](#) also contains details of the methods and evidence used to update these recommendations. The recommendations on exercise in lymphoedema are also relevant for people with [early or locally advanced breast cancer](#).

This 2014 update assesses exercise in people with or at risk of breast-cancer-related lymphoedema. Because of the variation between the exercise programmes in the included studies, it was not possible to define the frequency and intensity of the exercise programmes that may be undertaken. The exercise programmes that were included could reasonably be completed at gyms or similar facilities, or at home.

The 2009 guideline updated and replaced the following technology appraisals:

- 'Guidance on the use of capecitabine for the treatment of locally advanced or metastatic breast cancer' (NICE technology appraisal guidance 62)
- 'Guidance on the use of vinorelbine for the treatment of advanced breast cancer' (NICE technology appraisal guidance 54)
- 'Taxanes for the treatment of breast cancer' (NICE technology appraisal guidance 30).

Breast cancer is the most common cancer affecting women in England and Wales, with about 40,500 new cases diagnosed and 10,900 deaths recorded in England and Wales each year. In men breast cancer is rare, with about 260 cases diagnosed and 68 deaths in England and Wales each year.^{[1],[2]} Of these new cases in women and men, a small proportion is diagnosed in the advanced stages, when the tumour has spread significantly within the breast or to other organs of the body. In addition, there are a significant number of women who have been previously treated with curative intent who subsequently develop either a local recurrence or metastases. Over recent years there have been important developments in the investigation and management of patients with advanced breast cancer, including new chemotherapy, and biological and hormonal agents. There is some evidence of practice variation across the country and of patchy availability of certain treatments and procedures. This clinical guideline helps to address these issues and offers guidance on best practice.

Drug recommendations

The guideline will assume that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients.

This guideline recommends some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The patient (or those with authority to give consent on their behalf) should provide informed consent, which should be documented. See the General Medical Council's [Good practice in prescribing and managing medicines and devices](#) for further information. Where recommendations have been made for the use of drugs outside their licensed indications ('off-label use'), these drugs are marked with a footnote in the recommendations.

^[1] Office for National Statistics (2008) Cancer statistics registrations: registrations of cancer diagnosed in 2005, England. Series MB1 number 36. London: Office for National Statistics.

^[2] Welsh Cancer Intelligence and Surveillance Unit (2008) Cancer incidence in Wales 1992–2002. Cardiff: Welsh Cancer Intelligence and Surveillance Unit.

Patient-centred care

This guideline offers best practice advice on the care of patients with advanced breast cancer.

Patients and healthcare professionals have rights and responsibilities as set out in the [NHS Constitution for England](#) – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If the patient is under 16, their family or carers should also be given information and support to help the child or young person to make decisions about their treatment. Healthcare professionals should follow the [Department of Health's advice on consent](#). If someone does not have capacity to make decisions, healthcare professionals should follow the [code of practice that accompanies the Mental Capacity Act](#) and the supplementary [code of practice on deprivation of liberty safeguards](#).

NICE has produced guidance on the components of good patient experience in adult NHS services. All healthcare professionals should follow the recommendations in [Patient experience in adult NHS services](#).

Key priorities for implementation

Diagnosis and assessment

- Positron emission tomography fused with computed tomography (PET-CT) should only be used to make a new diagnosis of metastases for patients with breast cancer whose imaging is suspicious but not diagnostic of metastatic disease. [2009]
- Assess oestrogen receptor (ER) and human epidermal growth factor receptor 2 (HER2) status at the time of disease recurrence if receptor status was not assessed at the time of initial diagnosis. In the absence of tumour tissue from the primary tumour, and if feasible, obtain a biopsy of a metastasis to assess ER and HER2 status. [2009]

Systemic disease-modifying therapy

- Offer endocrine therapy as first-line treatment for the majority of patients with ER-positive advanced breast cancer. [2009]
- For patients with advanced breast cancer who are not suitable for anthracyclines (because they are contraindicated or because of prior anthracycline treatment either in the adjuvant or metastatic setting), systemic chemotherapy should be offered in the following sequence:
 - first line: single-agent docetaxel
 - second line: single-agent vinorelbine or capecitabine
 - third line: single-agent capecitabine or vinorelbine (whichever was not used as second-line treatment). [2009]
- For patients who are receiving treatment with trastuzumab^[a] for advanced breast cancer, discontinue treatment with trastuzumab at the time of disease progression outside the central nervous system. Do not discontinue trastuzumab if disease progression is within the central nervous system alone. [2009]

Supportive care

- Healthcare professionals involved in the care of patients with advanced breast cancer should ensure that the organisation and provision of supportive care services comply with the recommendations made in Improving outcomes in breast cancer: manual update (NICE cancer service guidance [2002]) and Improving supportive and palliative care for adults with cancer (NICE cancer service guidance [2004]), in particular the following two recommendations:

- 'Assessment and discussion of patients' needs for physical, psychological, social, spiritual and financial support should be undertaken at key points (such as diagnosis; at commencement, during, and at the end of treatment; at relapse; and when death is approaching).'
- 'Mechanisms should be developed to promote continuity of care, which might include the nomination of a person to take on the role of "key worker" for individual patients.' [2009]

Managing complications

- A breast cancer multidisciplinary team should assess all patients presenting with uncontrolled local disease and discuss the therapeutic options for controlling the disease and relieving symptoms. [2009]
- Consider offering bisphosphonates to patients newly diagnosed with bone metastases, to prevent skeletal-related events and reduce pain. [2009]
- Use external beam radiotherapy in a single fraction of 8Gy to treat patients with bone metastases and pain. [2009]
- Offer surgery followed by whole brain radiotherapy to patients who have a single or small number of potentially resectable brain metastases, a good performance status and who have no or well-controlled other metastatic disease. The following recommendations have been identified as priorities for implementation. The full list of recommendations is in section 1. [2009]

^[3] Recommendations on the use of trastuzumab are covered by [Guidance on the use of trastuzumab for the treatment of advanced breast cancer](#) (NICE technology appraisal guidance 34; 2002), which will be updated.

1 Recommendations

The following guidance is based on the best available evidence. The [full guideline](#) gives details of the methods and the evidence used to develop the guidance.

1.1 *Diagnosis and assessment*

Imaging assessment

- 1.1.1 Assess the presence and extent of visceral metastases using a combination of plain radiography, ultrasound, computed tomography (CT) scans and magnetic resonance imaging (MRI). [2009]
- 1.1.2 Assess the presence and extent of metastases in the bones of the axial skeleton using bone windows on a CT scan or MRI or bone scintigraphy. [2009]
- 1.1.3 Assess proximal limb bones for the risk of pathological fracture in patients with evidence of bone metastases elsewhere, using bone scintigraphy and/or plain radiography. [2009]
- 1.1.4 Use MRI to assess bony metastases if other imaging is equivocal for metastatic disease or if more information is needed (for example, if there are lytic metastases encroaching on the spinal canal). [2009]
- 1.1.5 Positron emission tomography fused with computed tomography (PET-CT) should only be used to make a new diagnosis of metastases for patients with breast cancer whose imaging is suspicious but not diagnostic of metastatic disease. [2009]

Pathological assessment

- 1.1.6 Patients with tumours of known oestrogen receptor (ER) status whose disease recurs should not have a further biopsy just to reassess ER status. [2009]
- 1.1.7 Patients with tumours of known human epidermal growth factor receptor 2 (HER2) status whose disease recurs should not have a further biopsy just to reassess HER2 status. [2009]

- 1.1.8 Assess ER and HER2 status at the time of disease recurrence if receptor status was not assessed at the time of initial diagnosis. In the absence of tumour tissue from the primary tumour, and if feasible, obtain a biopsy of a metastasis to assess ER and HER2 status. [2009]

Monitoring disease status

- 1.1.9 Do not use bone scintigraphy to monitor the response of bone metastases to treatment. [2009]
- 1.1.10 Do not use PET-CT to monitor advanced breast cancer. [2009]

1.2 *Providing information and support for decision making*

- 1.2.1 Assess the patient's individual preference for the level and type of information. Reassess this as circumstances change. [2009]
- 1.2.2 On the basis of this assessment, offer patients consistent, relevant information and clear explanations, and provide opportunities for patients to discuss issues and ask questions. [2009]
- 1.2.3 Assess the patient's individual preference for how much they wish to be involved in decision making. Reassess this as circumstances change. [2009]
- 1.2.4 Be aware of the value of decision aids and the range available. Make the most appropriate decision aid available to the patient. [2009]

1.3 *Systemic disease-modifying therapy*

- 1.3.1 Offer endocrine therapy as first-line treatment for the majority of patients with ER-positive advanced breast cancer. [2009]
- 1.3.2 Offer chemotherapy as first-line treatment for patients with ER positive advanced breast cancer whose disease is imminently life-threatening or requires early relief of symptoms because of significant visceral organ involvement, providing they understand and are prepared to accept the toxicity. [2009]

- 1.3.3 For patients with ER-positive advanced breast cancer who have been treated with chemotherapy as their first-line treatment, offer endocrine therapy following the completion of chemotherapy. [2009]

Endocrine therapy

- 1.3.4 Offer an aromatase inhibitor (either non-steroidal or steroidal) to:
- postmenopausal women with ER-positive breast cancer and no prior history of endocrine therapy
 - postmenopausal women with ER-positive breast cancer previously treated with tamoxifen. [2009]
- 1.3.5 Offer tamoxifen and ovarian suppression as first-line treatment to premenopausal and perimenopausal women with ER-positive advanced breast cancer not previously treated with tamoxifen. [2009]
- 1.3.6 Offer ovarian suppression to premenopausal and perimenopausal women who have previously been treated with tamoxifen and then experience disease progression. [2009]
- 1.3.7 Offer tamoxifen as first-line treatment to men with ER-positive advanced breast cancer. [2009]

Chemotherapy

- 1.3.8 On disease progression, offer systemic sequential therapy to the majority of patients with advanced breast cancer who have decided to be treated with chemotherapy. [2009]
- 1.3.9 Consider using combination chemotherapy to treat patients with advanced breast cancer for whom a greater probability of response is important and who understand and are likely to tolerate the additional toxicity. [2009]
- 1.3.10 For patients with advanced breast cancer who are not suitable for anthracyclines (because they are contraindicated or because of prior anthracycline treatment either in the adjuvant or metastatic setting), systemic chemotherapy should be offered in the following sequence:

- first line: single-agent docetaxel
- second line: single-agent vinorelbine or capecitabine
- third line: single-agent capecitabine or vinorelbine (whichever was not used as second-line treatment). [2009]

1.3.11 Gemcitabine in combination with paclitaxel, within its licensed indication, is recommended as an option for the treatment of metastatic breast cancer only when docetaxel monotherapy or docetaxel plus capecitabine are also considered appropriate^[4]. [2009]

Biological therapy

1.3.12 For patients who are receiving treatment with trastuzumab^[5] for advanced breast cancer, discontinue treatment with trastuzumab at the time of disease progression outside the central nervous system. Do not discontinue trastuzumab if disease progression is within the central nervous system alone. [2009]

1.4 Supportive care

1.4.1 Healthcare professionals involved in the care of patients with advanced breast cancer should ensure that the organisation and provision of supportive care services comply with the recommendations made in Improving outcomes in breast cancer: manual update (NICE cancer service guidance [2002]) and Improving supportive and palliative care for adults with cancer (NICE cancer service guidance [2004]), in particular the following two recommendations:

- 'Assessment and discussion of patients' needs for physical, psychological, social, spiritual and financial support should be undertaken at key points (such as diagnosis; at commencement, during, and at the end of treatment; at relapse; and when death is approaching).'
- 'Mechanisms should be developed to promote continuity of care, which might include the nomination of a person to take on the role of "key worker" for individual patients.' [2009]

1.5 *Managing complications*

Lymphoedema

- 1.5.1 Discuss with people who have or who are at risk of breast-cancer related lymphoedema that there is no indication that exercise prevents, causes or worsens lymphoedema. [new 2014]
- 1.5.2 Discuss with people who have or who are at risk of breast cancer related lymphoedema that exercise may improve their quality of life. [new 2014]
- 1.5.3 Assess patients with lymphoedema for treatable underlying factors before starting any lymphoedema management programme. [2009]
- 1.5.4 Offer all patients with lymphoedema complex decongestive therapy (CDT) as the first stage of lymphoedema management. [2009]
- 1.5.5 Consider using multilayer lymphoedema bandaging (MLLB) for volume reduction as a first treatment option before compression hosiery. [2009]
- 1.5.6 Provide patients with lymphoedema with at least two suitable compression garments. These should be of the appropriate class and size, and a choice of fabrics and colours should be available. [2009]
- 1.5.7 Provide patients with lymphoedema with clear, written information and the contact details of local and national lymphoedema support groups. [2009]

Cancer-related fatigue

- 1.5.8 Offer all patients with advanced breast cancer for whom cancer related fatigue is a significant problem an assessment to identify any treatable causative factors, and offer appropriate management as necessary. [2009]
- 1.5.9 Provide clear, written information about cancer-related fatigue, organisations that offer psychosocial support and patient led groups. [2009]
- 1.5.10 Provide information about and timely access to an exercise programme for all patients with advanced breast cancer experiencing cancer-related fatigue. [2009]

Uncontrolled local disease

- 1.5.11 A breast cancer multidisciplinary team should assess all patients presenting with uncontrolled local disease and discuss the therapeutic options for controlling the disease and relieving symptoms. [2009]
- 1.5.12 A wound care team should see all patients with fungating tumours to plan a dressing regimen and supervise management with the breast care team. [2009]
- 1.5.13 A palliative care team should assess all patients with uncontrolled local disease in order to plan a symptom management strategy and provide psychological support. [2009]

Bone metastases

- 1.5.14 Consider offering bisphosphonates to patients newly diagnosed with bone metastases to prevent skeletal-related events and reduce pain. [2009]
- 1.5.15 The choice of bisphosphonate for patients with bone metastases should be a local decision, taking into account patient preference and limited to preparations licensed for this indication. [2009]
- 1.5.16 Use external beam radiotherapy in a single fraction of 8Gy to treat patients with bone metastases and pain. [2009]
- 1.5.17 An orthopaedic surgeon should assess all patients at risk of a long bone fracture, to consider prophylactic surgery. [2009]

Brain metastases

- 1.5.18 Offer surgery followed by whole brain radiotherapy to patients who have a single or small number of potentially resectable brain metastases, a good performance status and who have no or well controlled other metastatic disease. [2009]
- 1.5.19 Offer whole brain radiotherapy to patients for whom surgery is not appropriate, unless they have a very poor prognosis. [2009]

- 1.5.20 Offer active rehabilitation to patients who have surgery and/or whole brain radiotherapy. [2009]
- 1.5.21 Offer referral to specialist palliative care to patients for whom active treatment for brain metastases would be inappropriate. [2009]

^[4] This recommendation is from [Gemcitabine for the treatment of metastatic breast cancer](#) (NICE technology appraisal guidance 116; 2007). It was formulated as part of that technology appraisal and not by the guideline developers. It has been incorporated into this guideline in line with NICE procedures for developing clinical guidelines, and the evidence to support the recommendation is available.

^[5] Recommendations on the use of trastuzumab are covered by [Guidance on the use of trastuzumab for the treatment of advanced breast cancer](#) (NICE technology appraisal guidance 34; 2002), which will be updated.

2 Research recommendations

In 2009 the Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The Guideline Development Group's full set of research recommendations is detailed in the full guideline. As part of the 2014 update the Standing Committee made an additional research recommendation on breast cancer related lymphoedema. This can be found in the [addendum](#).

2.1 *Endocrine therapy*

Clinical trials are needed to investigate the most effective endocrine therapy for postmenopausal women with ER-positive tumours who progress on treatment with an aromatase inhibitor.

Why this is important

Although there is good evidence to support the use of aromatase inhibitors for postmenopausal women with ER-positive tumours, there is little evidence to determine what is the best sequence of alternative hormone treatments when they progress.

2.2 *Chemotherapy*

Randomised clinical trials should evaluate the clinical and cost effectiveness of different sequences of chemotherapy for advanced breast cancer.

Why this is important

Most patients with advanced breast cancer who receive chemotherapy will be given at least two different regimens and many will receive three. The available evidence to support decisions about the most clinically and cost effective sequence in which to use these drugs is extremely limited. There is also very little good-quality evidence about the relative clinical and cost effectiveness of currently recommended treatments, either in combination or in sequence. Following on from the recommendations in this guideline, it would be important to establish clinical trials to investigate this problem in a more systematic fashion than hitherto.

2.3 *Biological response modifiers (progressive metastatic disease)*

The use of continued trastuzumab in patients with progressive metastatic disease should be investigated as part of a randomised controlled trial. Trial design should incorporate collection of data required for prospective cost effectiveness analysis.

Why this is important

There is currently no high-quality published evidence about whether continuing trastuzumab is effective in prolonging survival in patients with HER2-positive advanced breast cancer who develop progressive disease (outside the central nervous system) during or after first-line treatment with trastuzumab and cytotoxic chemotherapy. Any studies should be carefully planned to permit a high quality cost-effectiveness analysis.

2.4 *Biological response modifiers (adjuvant trastuzumab)*

Randomised controlled trials are needed to assess whether patients who have had adjuvant trastuzumab should be offered further biological response modifiers. Trial design should incorporate collection of data required for prospective cost-effectiveness analysis.

Why this is important

As more patients with HER2-positive advanced breast cancer have trastuzumab as part of their initial adjuvant treatment following a diagnosis of early breast cancer, an increasing number of patients with advanced breast cancer will have had previous exposure to this agent. There is no evidence currently about whether trastuzumab or other biological therapies are effective in this situation.

2.5 *Uncontrolled local disease*

The relevant research organisations should be encouraged to address the topic of uncontrolled local disease and devise appropriate research studies. This might include development of a national register.

Why this is important

The problem of how best to manage uncontrolled local disease is very poorly addressed by the current evidence. Although it is probably quite an uncommon condition, it is likely that across the

country there are enough patients to generate evidence from well-coordinated national studies. A national register should be considered as part of this because of the current uncertainties about the frequency of the problem.

3 Other information

3.1 *Scope and how this guideline was developed*

The [scope](#) for the original NICE clinical guideline 81 (published February 2009) covers the recommendations labelled [2009], and the [scope](#) for the updated NICE clinical guideline covers the recommendations labelled [new 2014].

Groups that will be covered

- Women and men with invasive adenocarcinoma of the breast of clinical stage 4 (that is, with known metastatic disease).

Groups that will not be covered

- Women and men with invasive adenocarcinoma of the breast of clinical stages 1, 2 and 3 (this is covered by the NICE guideline on 'Early and locally advanced breast cancer: diagnosis and treatment').
- Women and men with metastases to the breast from other primary tumours.
- Women and men with rare breast tumours (for example, angiosarcoma, lymphoma).
- Women and men with benign breast tumours (for example, fibroadenoma, benign phyllodes tumours).

How this guideline was developed

NICE's Clinical Guidelines Update Programme updated this guideline. These guidelines are updated using a standing committee of healthcare professionals and lay members from a range of disciplines and localities. For the duration of the update the core members of the committee are joined by up to five additional members who have specific expertise in the topic being updated. All of the standing members and the topic specific members are fully voting members of the committee.

The methods and processes for developing NICE clinical guidelines are described in [The guidelines manual](#). The interim process and methods guide for the clinical guideline rapid updates pilot programme (2013) are described [here](#).

3.2 *Related NICE guidance*

Details are correct at the time of publication of the guideline (July 2014). Further information is available on the [NICE website](#).

Published

General

- [Patient experience in adult NHS services](#). NICE clinical guidance 138 (2012).
- [Medicines adherence](#). NICE clinical guidance 76 (2009).

Condition-specific

- Everolimus in combination with exemestane for treating advanced HER2-negative hormone-receptor-positive breast cancer after endocrine therapy. [NICE technology appraisal guidance 295](#) (2013).
- Familial breast cancer: classification and care of people at risk of familial breast cancer and management of breast cancer and related risks in people with a family history of breast cancer. [NICE clinical guideline 164](#) (2013).
- Bevacizumab in combination with capecitabine for the first-line treatment of metastatic breast cancer. [NICE technology appraisal guidance 263](#) (2012).
- Fulvestrant for the treatment of locally advanced or metastatic breast cancer. [NICE technology appraisal guidance 239](#) (2011).
- Bevacizumab in combination with a taxane for the first-line treatment of metastatic breast cancer. [NICE technology appraisal guidance 214](#) (2011).
- Early and locally advanced breast cancer: diagnosis and treatment. [NICE clinical guideline 80](#) (2009).
- Alendronate, etidronate, risedronate, raloxifene, strontium ranelate and teriparatide for the secondary prevention of osteoporotic fragility fractures in postmenopausal women (update of technology appraisal guidance 87) [NICE technology appraisal guidance 161](#) (2008).
- Alendronate, etidronate, risedronate, raloxifene and strontium ranelate for the primary prevention of osteoporotic fragility fractures in postmenopausal women. [NICE technology appraisal guidance 160](#) (2008).

- Gemcitabine for the treatment of metastatic breast cancer. [NICE technology appraisal guidance 116](#) (2007).
- Improving supportive and palliative care for adults with cancer. [Cancer service guidance](#) (2004).
- Improving outcomes in breast cancer – manual update. [Cancer service guidance](#) (2002).
- Guidance on the use of trastuzumab for the treatment of advanced breast cancer. [NICE technology appraisal guidance 34](#) (2002).

Under development

NICE is developing the following guidance (details available from [the NICE website](#)):

Referral guidelines for suspected cancer (update). NICE clinical guideline. Publication expected May 2015.

Standing Committee A and NICE project team

3.3 *Standing Committee A*

The Committee members listed are those for the 2014 update. For the composition of (the) previous Guideline Development Group, see the full guideline.

Standing committee members

Damien Longson, Chair

Consultant Liaison Psychiatrist, Manchester Mental Health and Social Care Trust

Susan Bewley, Vice Chair

Honorary Professor of Complex Obstetrics, Women's Academic Health Centre, St Thomas' Hospital

Catherine Briggs

GP Principal, Bracondale Medical Centre, Stockport

John Cape

Director of Psychological Therapies Programmes, University College London

Alun Davies

Professor of Vascular Surgery and Honorary Consultant Surgeon, Charing Cross & St Mary's Hospital & Imperial College NHS Trust

Alison Eastwood

Senior Research Fellow, Centre for Reviews and Dissemination, University of York

Sarah Fishburn

Lay Member

Amanda Gibbon (until March 2014)

Lay Member

Jim Gray

Consultant Medical Microbiologist, The Birmingham Children's Hospital NHS Foundation Trust

Nuala Lucas

Consultant Anaesthetist, Northwick Park Hospital, Middlesex

Kath Nuttall

Director, Lancashire & South Cumbria Cancer Network (- April 2013)

Tilly Pillay

Consultant Neonatologist, Staffordshire, Shropshire and Black Country Newborn Network, Royal Wolverhampton Hospitals Trust

Nick Screatton

Radiologist, Papworth Hospital NHS Foundation Trust

Lindsay Smith

Principal in General Medical Practice, Somerset PCT

Philippa Williams (from March 2014)

Lay Member

Sophie Wilne

Paediatric Oncologist, Nottingham Children's Hospital

Topic-specific committee members

Jane Board

Lymphoedema Clinical Nurse Specialist, Lymphoedema Specialist Services Ltd

Kate Gowans

Lymphoedema Practitioner, South Tees NHS Trust

Vaughan Keeley

Consultant in Lymphoedema / Palliative Medicine, Derby Hospitals NHS Foundation Trust

Netta Wooles

Lay member

3.4 *Clinical Guidelines Update Team*

Susan Ellerby

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3.5 *NICE project team*

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About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions.

NICE guidelines are developed in accordance with a [scope](#) that defines what the guideline will and will not cover.

This guideline was developed by the NICE Clinical Guidelines Update Programme. The Clinical Guidelines Update Programme worked with a Standing Committee, comprising healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, which reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in [The guidelines manual](#).

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Update information

The NICE Clinical Guidelines Update Programme updates discrete parts of published clinical guidelines as requested by NICE's Guidance Executive.

Suitable topics for update are identified through the new surveillance programme ([see surveillance programme interim guide](#)).

The surveillance programme when reviewing the Advanced Breast Cancer guideline identified new evidence in relation to the role of exercise in people who have, or are at risk of, breast cancer related lymphoedema. The [full surveillance review decision](#) is available on the NICE website.

New recommendations on lymphoedema have been added to the [Managing complications](#) section.

This update is an addendum to NICE clinical guideline 81, but is also relevant to the population covered in [Early and locally advanced breast cancer](#) (NICE clinical guideline 80). New and updated recommendations are marked as:

- **[new 2014]** if the evidence has been reviewed and the recommendation has been added or updated

Where recommendations end **[2009]**, the evidence has not been reviewed since the original guideline. The original NICE guideline and supporting documents are available [here](#).

Strength of recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the Guideline Development Group is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

For all recommendations, NICE expects that there is discussion with the patient about the risks and benefits of the interventions, and their values and preferences. This discussion aims to help them to reach a fully informed decision (see also [Patient-centred care](#)).

Interventions that must (or must not) be used

We usually use 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally we use 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions that should (or should not) be used – a 'strong' recommendation

We use 'offer' (and similar words such as 'refer' or 'advise') when we are confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective. We use similar forms of words (for example, 'Do not offer...') when we are confident that an intervention will not be of benefit for most patients.

Interventions that could be used

We use 'consider' when we are confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient.

Other versions of this guideline

The [full guideline](#), 'Advanced breast cancer: diagnosis and treatment' contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Cancer.

The recommendations from this guideline have been incorporated into a [NICE Pathway](#).

We have produced [information for the public](#) about this guideline.

Implementation

[Implementation tools and resources](#) to help you put the guideline into practice are also available.

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summaries of product characteristics of any drugs.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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