Early and locally advanced breast cancer (update) workshop
03.05.16

Table 1. Summary of the workshop group member discussions according to each section of the scope.

Topic		Notes
4.1	**Population**	
4.1.1	**Groups that will be covered**	
		Discussion on recurrent breast cancer which has been excluded so far – no decision was reached, but stakeholders suggested that it might fall under locally advanced if it was curable. Stakeholders queried why LCIS had not been included – suggested that it is not managed as breast cancer and that is why it has not been included. DCIS was also discussed as to whether it should be included given there is not a specific question in the scope. A longer discussion took place about those with a family history in terms of the impact on treatment and more requests by patients for testing. It was suggested that patients with breast cancer and who are subsequently found to have a family history risk fall between this guideline and the Familial Breast Cancer guideline (CG164). It was suggested that these patients fit neater into this guideline than CG164. It was agreed there should be a question on this population e.g. which women to consider for testing. CG164 is currently being reviewed for possible update and this topic could be integrated into that update. Further discussion would be needed on this between NICE and the NGA.
4.1.2	**Groups that will not be covered**	
		The developers explained that there was already a NICE suspected cancer guideline and an osteoporosis guideline, hence these two groups are not included in the scope. There was general agreement that (line 70) was not going be updated given that triple assessment was established. However, it was mentioned that the later topic on the management of the positive axilla may have implications for diagnosis as it will be important to define the positive axilla. One stakeholder informed the group that the screening programme are updating their guidelines and they will include the positive axilla. There was also a discussion about gene profiling in terms of when it is used for diagnosis and when it is used later in the patient pathway. The issues of information and communication around this topic was also discussed. Another stakeholder suggested that (line 71) surgery to the breast should be included. Neoadjuvant therapy has to tie in with the surgery, however it was noted that this was covered by the topic on neoadjuvant therapy. Also there is uncertainty over margins and testing for margins after mastectomy and whether it actually is

Topic		Notes
		happening in practice. It was agreed there are no recommendations currently on this but lots of variation. It was noted that the ABS (Association of Breast Surgeons) produced guidelines last year on this topic. Stakeholders discussed the differences in terms of breast conserving surgery and DCIS after mastectomy, and how a patient is not followed up in the screening programme after having a mastectomy. Also how a patient may receive radiotherapy or oncological therapy if close margins were reported. Stakeholders concluded that margins was an important issue that needs covering in the guideline. Lymphoedema was raised as a really important issue. It was suggested that new evidence and changes in practice had been introduced since the original guideline was published. There is known variation in practice. It was noted that there is a 20% likelihood of lymphoedema in patients with early and locally advanced breast cancer which is not being treated early enough so it would be useful if this guideline could address surveillance and early intervention. There was an assumption that it is only relevant to advanced disease but actually fits into the early and locally advanced disease too. NGA and NICE reps discussed that there had already been an update to the lymphoedema topic within the Advanced Breast Cancer guideline (CG81) but this only covered exercise. There was also a discussion about contraception and future pregnancies for breast cancer patients. The developers noted that RCOG have published guidance on this. Stakeholders also discussed fertility and issues, particularly around information and communication.
4.3	**Management**	
4.3.1	**Key issues that will be covered**	
	Management of the positive axilla	Stakeholders questioned how it is diagnosed/defined.
	Adjuvant systemic treatment planning	Optimal biomarkers to be used as prognostic tools was suggested as an additional question.
	Endocrine therapy for invasive disease	Stakeholders suggested including local recurrence in this topic.
	Adjuvant chemotherapy	The current guideline only talks about node positive disease. Should platinum be included? An additional question on the general management of triple negative patients was suggested. However the difficulty of defining triple negative was noted.
	Adjuvant biological therapy	It was noted that a possible TA on Pretuzumab is in development for this topic.
	Adjuvant bisphosphonates	It was noted that the potential toxicities of this treatment sometimes outweigh the benefits. A European consensus

Topic		Notes
		statement on this was issued in January 2016.
	Breast radiotherapy	Stakeholders were reminded that the reason for including these questions was to cover changing radiotherapy techniques and the wide variation in practice. A question was raised as to whether these topics would update guidance on intraoperative radiotherapy and it was suggested that they would.
	Post mastectomy radiotherapy	The importance of breast reconstruction and the variation in the threshold for surgery were discussed. Who should be offered immediate reconstruction? Is radiotherapy 'harmful' to reconstruction? Currently there is variation in practice. Sometimes immediate reconstruction is offered but in other places reconstruction is delayed until after patients have been irradiated It was agreed that this is an important area which needs covering by the guideline.
	Neoadjuvant therapy	Optimal surgery to the breast was suggested for inclusion in this topic.
	Lifestyle	It was suggested that the scope should be amended to 'cancer specific survival' rather than just 'survival' to focus the question more. There was discussion as to whether complementary therapies should be included here. Stakeholders also considered whether the DH policy on Recovery Package overlaps with this topic. General consensus was that this could be a really useful topic for the guideline. The disparity to access diet/nutritional advice during any stage of treatment was raised. This is a timely question due to the 10 year global perspective on diet and food nutrition which will be reported within the next year.
Additional topics to include		

Table 2. Summary of the workshop group member discussions concerning the proposed GC member and expert advisor lists.

Proposed GDG member
General agreement with the list as it stands. Stakeholders queried whether a radiologist was required since there were no questions covering diagnosis. There was agreement that a radiologist would be required as they are useful at other stages in the treatment pathway (such as assessing treatment response) and are vital members of the MDT. It was suggested that it would depend on the final list of topics/questions as to whether you'd need additional members, and whether they could be 'expert advisors' rather than permanent GC members. Suggested experts advisors are: - Medical Physicist/Clinical Scientist - Lymphoedema Specialist - Geneticist/Genetic Counsellor - Complementary Therapist - Dietician/Nutritional Therapist