**Cardiff Breast Centre- Update for General Practice**

**January 2020**

The Breast Centre at University Hospital Llandough receives > 450 referrals a month from General Practitioners. 60% of those referrals are referred by GPs as URGENT Suspected Cancers (USC), although < 6% of those referrals turn out to be cancer.

At the current time it is impossible to meet the targets for a 2 week wait for all USC referrals due to the high numbers of referrals. All referrals are vetted by Consultants and those referrals that seem highly likely to be breast cancer are expedited and seen as soon as possible (usually within 2 weeks). Other USC referrals are usually seen within 3-4 weeks.

Many patients we see are surprised that they have been referred to the clinic and have been anxious following the referral. Those patients who are classified as urgent / routine by the GPs are seen within 6 months of referral (although all referrals are vetted by Consultants in the Breast Centre and many who are > 30 years with a breast lump are upgraded to USC to fit with NICE guidelines).

Some of the patients (approx. 30%) who are classified as non- USC, tell us that they do not need the appointment when offered an appointment several months after the referral as the problem has resolved.

In order to deal appropriately with the large number of referrals we hope the attached FAQs and flow charts will provide you with some guidance as to how to manage common benign breast problems and help you to be more confident about who should be referred for further assessment.

Further information can be found on the Cardiff Breast Centre website, which contains links to other useful information:

[www.cardiffandvaleuhb.wales.nhs.uk/the-breast-centre-uhl/](http://www.cardiffandvaleuhb.wales.nhs.uk/the-breast-centre-uhl/)

**The Breast Centre can also be contacted for advice rather than referral using the Wales Clinical Portal System. This is monitored daily from Monday-Friday, by consultants.**

**Requests for Ultrasound only**: These are also managed by the radiology team in the Breast Centre so are prioritised in the same way. Requests for US of the breast will be managed through an appointment in a Breast Clinic.

Some requests for US of the axilla will be managed outside of the clinics. In order to prioritise the appointments, it would be helpful if requests could indicate what you think is the likely clinical diagnosis.

**Here are some FAQs and some flow charts to help GPs to assess and manage common benign breast problems.**

**Frequently Asked Questions**

**1.Which patients should be referred using ‘Urgent Suspected Cancer’ pathway referral – USC route (for an appointment within 2 weeks)?**

Refer people for suspected breast cancer if they are:

* aged 30 and over and have an unexplained breast lump with or without pain or
* aged 50 and over with any of the following symptoms in one nipple only: discharge, retraction or other changes of concern. [new 2015]
* with skin changes that suggest breast cancer or
* aged 30 and over with an unexplained lump in the axilla. [new 2015]

Consider **non-urgent referral** in people aged under 30 with an unexplained breast lump with or without pain.

*Taken from: NICE Guidelines:’ Suspected cancer: recognition and referral’*

*Published date: June 2015 Last updated: July 2017*

**See Flow Chart for assessment and management of breast lumps.**

**2.Which patients can be managed initially by their General Practitioner?**

* Young women with tender, lumpy breasts and older women with symmetrical nodularity, provided there is no localised abnormality
* Cyclical breast pain is a normal physiological phenomenon and therefore women with minor and moderate degrees of cyclical breast pain who do not have a discrete palpable lesion.
* Women who have symptoms and signs of musculoskeletal pain – such as chest wall tenderness and costochondritis, with a normal breast examination.

<https://www.breastcancercare.org.uk/information-support/have-i-got-breast-cancer/benign-breast-conditions/breast-pain>

**See Flow Chart for assessment and management of breast pain.**

* Women< 50 years who have nipple discharge that comes from more than one duct and is a yellow/ green / brown or is intermittent and is neither blood stained nor troublesome. This is likely to be due to duct ectasia.

<https://www.breastcancercare.org.uk/information-support/have-i-got-breast-cancer/duct-ectasia>

**See Flow Chart for assessment and management of nipple discharge.**

* Women who have eczema / skin rashes affecting the areola and other areas of the breast. The nipple is normal. **(NB *Paget’s disease starts from the nipple and spreads to areola*).**

Information about benign breast problems can be found on the following link:

<https://www.breastcancercare.org.uk/information-support/have-i-got-breast-cancer/benign-breast-conditions>

**3. How should breast infections be managed?**

Breast infection is common and most cases can be managed by GPs in the first instance.

NB *Inflammatory breast cancer is very rare and patients do not have systemic symptoms of infection.*

Common causes of breast infection are:

* Post-partum mastitis, ie usually in first few weeks of breast feeding,
* Periductal mastitis- occurs in women 30s-50s, who develop peri-areola infection, which is often recurrent
* Skin infections which happen to be on the breast- eg infected sebaceous cysts

Guidance on how to manage these infections is on the following link:

<http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/BREAST%20infection%20final.pdf>

**4. What is a ‘strong family history’?**

The criteria for referral for assessment of a possible genetic risk of breast cancer are:

* Patients who have first degree relatives- FDR (mother, sister), who have had breast cancer < 40 years or have had bilateral breast cancer or have a father who has had breast cancer OR have a relative who had breast and ovarian cancer.
* Patients with two first degree relatives affected by breast cancer OR ovarian cancer at any age or a FDR + SDR of 2 relatives with breast or ovarian cancer.

*NB: Only 10% of Breast Cancers are genetic – eg BRCA1/2 or other rarer genetic mutations*

See Wales Cancer Genetics Service Guidelines for referral.

<http://www.wales.nhs.uk/sites3/Documents/525/Cancer%20-%20Ref%20Guidlines%202016.pdf>

**Patients who are asymptomatic and are concerned regarding a Family History should be referred directly to All Wales Cancer Genetics Service.**

**5. Which male patients with a breast swelling, need to be referred to the Breast Centre?**

Male patients with the following symptoms **do not need** to be referred but just need reassurance:

* Adolescent boys with breast swelling
* Young men who have tender bilateral gynaecomastia, related to use of anabolic steroids, recreational drugs and other supplements that may have been used in gyms.
* Older men with bilateral breast swelling that is related to underlying medical problems or side effects of medication.
* Requests for surgery for persistent gynaecomastia (if appropriate can be referred to Plastic Surgery Service in Morriston Hospital, but there are very specific criteria for referral- such as a BMI of 25 or less and a normal endocrine profile.

For further information on how to assess and manage Gynaecomastia see:

<https://www.breastcancercare.org.uk/information-support/have-i-got-breast-cancer/breast-pain-other-benign-conditions/gynaecomastia>

**Men with non-tender unilateral breast lumps for which there is no known cause should be assessed in the Breast Centre. *Male breast cancer is however uncommon.***

**6. What tests are used in the clinic?**

* Mammograms are only performed on symptomatic women > 40 years old.
* Ultrasound of localised areas of the breast can be performed for any symptomatic women.
* MRI is only used in a very small number of patients to provide additional information after mammograms.
* Swabs of nipple discharge are not needed as it is not usually due to infection.
* Prolactin measurement is only needed for assessment of significant galactorrhoea. It is not a cause of most nipple discharges.