Standard 4.6 – 2014 Pretreatment evaluation and first treatment consistent with nationally recognized guidelines

Pretreatment evaluation in adherence to nationally recognized guidelines

The NCCN guidelines recommend that clinical stage IIIA, IIIB and IIIC breast cancer patients be considered for CT of chest and abdomen even in the absence of symptoms as part of the pretreatment evaluation prior to surgery (there is a different pathway in the NCCN guideline for patients who will receive neoadjuvant/presurgery chemotherapy). A review of this institution's clinical stage IIIA-C breast cancer cases that were not being considered for preoperative chemotherapy revealed a total of 8 patients. 6 of these eight patients were evaluated prior to surgery with a chest and abdominal CT. Of the 2 patients who were not evaluated with chest and abdominal CT, one was 86 and was treated with neoadjuvant endocrine therapy and had no symptoms suggesting metastatic disease. The other patient had debatable clinical stage II vs III disease and also had no symptoms suggesting metastatic disease

The guidelines language stating "consider" pretreatment staging is used purposely as high quality data is not available to definitively state that patients with locally regionally advanced breast cancer patients are found to have metastatic often enough to always warrant pretreatment diagnostic radiographic evaluations. The characteristic of the patients who did not receive metastatic workups seems quite appropriate and we do not believe changes to our program need be considered.

Treatment in adherence to nationally recognized guidelines

NCCN guidelines recommend that patients with 1-3 involved axillary nodes treated with mastectomy and surgical axillary staging prior to chemotherapy should be considered for radiation therapy to the chest wall, +/- infraclavicular and supraclavicular nodes, and internal mammary nodes. Twelve patients were identified that met these criteria (1-3 involved nodes, treated with mastectomy and axillary dissection followed by chemotherapy). Nine of the 12 patients received radiation oncology evaluations, 3 patients did not, for a compliance rate of 75%.

Further review of the three patients that did not have radiation oncology consultations reveals that two of the patients lived over an hour from our chemotherapy and radiation therapy departments and were referred to a local medical oncologist with an office/infusion center located much closer to their homes. There is a radiation facility adjacent to this medical oncologist office/infusion center. However, contact with the administrator of the adjacent radiation facility revealed that the patient was not seen for consultation at that facility.

The third patient was treated by a Bon Secour medical oncologist but no evidence of radiation oncology evaluation or presentation at tumor board can be identified.

In the future, to ensure that patients with 1-3 axillary nodes are given the opportunity to meet and discuss the advantages and disadvantages of radiation with a radiation oncologist, we recommend that our Bon Secour breast surgeons make simultaneous referrals to medical oncology and radiation oncology when patients ask for referrals to center closer to home.