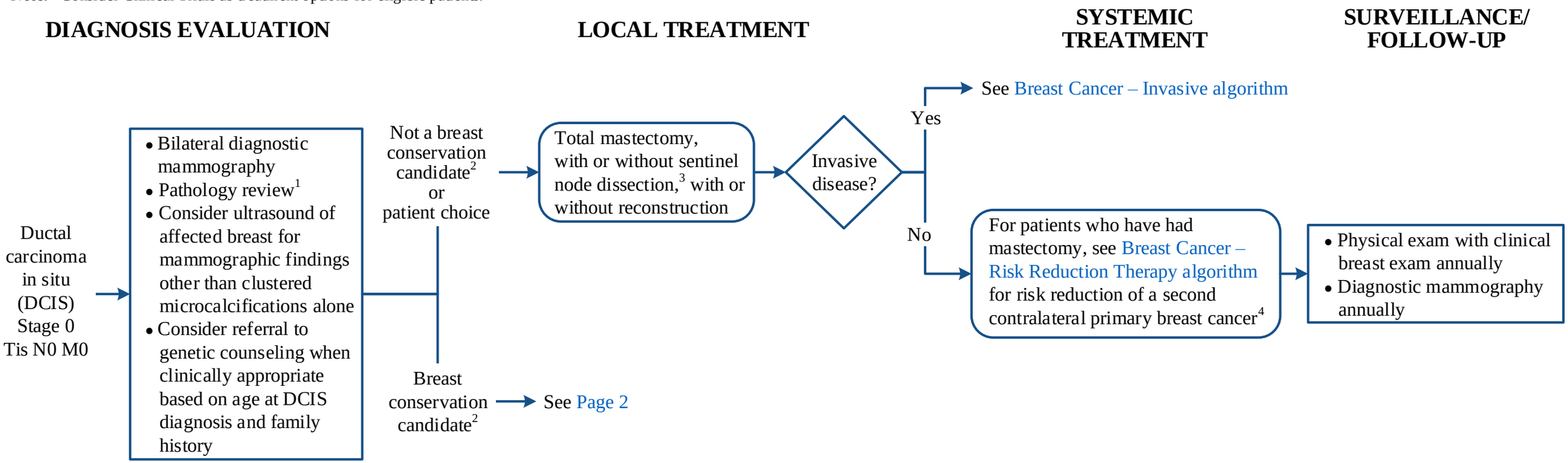
Breast Cancer – Noninvasive

Note: Consider Clinical Trials as treatment options for eligible patients.



[1] Pathology review to include:
- Tumor size
- Rule out invasive component
- Lymph node status if lymph node surgery performed
- Estrogen receptor (ER)/progesterone receptor (PR) status, preferably on the surgical specimen (unless patient is undergoing bilateral mastectomy)
- Margin status
- Nuclear grade
- Histologic type/necrosis

[2] Candidates for breast conservation therapy:
- Unicentric disease
- Tumor to breast size ratio allows for acceptable cosmetic result
- Attempt margins ≥ 2 mm
- No evidence of diffuse microcalcifications on mammography
- No contraindication to radiation therapy

[3] DCIS lymph node evaluation not recommended unless patient having total mastectomy which would preclude mapping at a later date if invasive disease noted on final pathology

[4] For ER or PR positive DCIS, endocrine therapy with tamoxifen for 5 years or aromatase inhibitor (AI) therapy is also an option for postmenopausal patients for risk reduction. See Breast Cancer – Risk Reduction Therapy algorithm for risk reduction of a second contralateral primary breast cancer. For patients who underwent bilateral mastectomy, there is zero indication for risk reduction therapy.

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Breast Cancer – Noninvasive

Note: Consider Clinical Trials as treatment options for eligible patients.

DIAGNOSIS EVALUATION

Breast conservation candidate[1]

Resect to obtain negative margins

Negative margins[2]?

LOCAL TREATMENT

Yes

Consider hypofractionation whole breast schedules for all patients, regardless of age

No

Positive margins:
- Re-excise **or**
- Total mastectomy, with or without sentinel node dissection[3], with or without reconstruction

SYSTEMIC TREATMENT

- For ER or PR positive DCIS, if breast conserving surgery and radiation[4]:
  - Endocrine therapy with tamoxifen for 5 years is recommended to lower risk of ipsilateral breast tumor recurrence
  - Aromatase inhibitor (AI) therapy is also an option for post-menopausal women
- For patients who have had mastectomy, see guidelines for risk reduction of a contralateral primary breast cancer[4]

SURVEILLANCE/ FOLLOW-UP

- Physical exam with clinical breast exam annually
- Diagnostic mammography 6-12 months after radiation therapy, then annually

[1] Candidates for breast conservation therapy:
- Unicentric disease
- Tumor to breast size ratio allows for acceptable cosmetic result
- No evidence of diffuse microcalcifications on mammography
- No contraindication to radiotherapy

[2] Negative net margins:
- If < 2 mm negative margins and planned radiation therapy, multidisciplinary planning to consider need to re-excise and consider radiation therapy boost 14-16 Gy as an alternative to re-excision
- If < 2 mm negative margins and no planned radiation therapy, re-excise

[3] DCIS lymph node evaluation not recommended unless patient having total mastectomy which would prelude mapping at a later date if invasive disease noted on final pathology.

[4] For ER or PR positive DCIS, if patient undergoes breast conserving surgery and radiation, endocrine therapy is recommended to lower risk of ipsilateral breast tumor recurrence. The magnitude of local recurrence risk reduction depends on absolute risk of local recurrence based on factors such as grade and size (molecular profiling impact still is uncertain). Tamoxifen 20 mg daily for 5 years is approved to lower ipsilateral breast tumor recurrence after breast conserving surgery and radiation. AI therapy (anastrazole 1 mg daily for 5 years) has been shown to be equally effective, yet not FDA-approved for this indication. Endocrine therapy can also be considered for ER or PR positive DCIS treated with breast conserving surgery without radiation, but less supportive data exists. For patients undergoing mastectomy, refer to breast cancer prevention guidelines for prevention of a contralateral breast cancer.

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Breast Cancer – Noninvasive

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