ASCO 2006 Guideline Update: Breast Cancer Follow-Up & Management in the Adjuvant Setting

	Previous Recommendation (1998)	Current Recommendation (2006)
Guideline Title	*American Society of Clinical Oncology 1998 Update of Recommended Breast Cancer Surveillance Guidelines*	*American Society of Clinical Oncology 2006 Update of the Breast Cancer Follow-Up and Management Guideline in the Adjuvant Setting*
Recommended Breast Cancer Surveillance		
Referral for Genetic Counseling	Not included in previous update.	Women at high risk for familial breast cancer syndromes should be referred for genetic counseling in accordance with clinical guidelines recommended by the U.S. Preventive Services Task Force. Criteria to recommend referral include: 1) Ashkenazi Jewish heritage; 2) history of ovarian cancer at any age in the patient or any first- or second-degree relatives; 3) any first degree relative with a history of breast cancer diagnosed before the age of 50; 4) two or more first- or second-degree relatives diagnosed with breast cancer at any age and; 5) patient or relative with diagnosis of bilateral breast cancer; 6) history of breast cancer in a male relative.
Mammography	It is prudent to recommend that all women with a prior diagnosis of breast cancer have yearly mammographic evaluation. Women treated with breast-conserving therapy should have their first posttreatment mammogram approximately 6 months after completion of radiotherapy and as indicated for surveillance of abnormalities or annually. If stability of mammographic findings is achieved, mammography can be performed yearly thereafter.	Women treated with breast-conserving therapy should have their first post-treatment mammogram no earlier than 6 months after definitive radiation therapy. Subsequent mammograms should be obtained every 6 to 12 months for surveillance of abnormalities. Mammography should be performed yearly if stability of mammographic findings is achieved after completion of locoregional therapy.
Coordination of Care	The majority of breast cancer recurrences will have occurred within the first 5 years after primary therapy. Subsequent care of the patient following primary treatment should be coordinated and not duplicated. In addition, continuity of care is encouraged and should be performed by a physician experienced in the surveillance of cancer patients and in breast examination, including the examination of irradiated breasts.	The risk of breast cancer recurrence continues through 15 years after primary treatment and beyond. Continuity of care for breast cancer patients is recommended and should be performed by a physician experienced in the surveillance of cancer patients and in breast examination, including the examination of irradiated breasts. Follow-up by a primary care physician (PCP) appears to lead to the same health outcomes as specialist follow-up with good patient satisfaction. If a patient with early-stage breast cancer (tumor <5cm and fewer than 4 positive nodes) desires follow-up exclusively by a PCP, care may be transferred to the PCP approximately one year after diagnosis. If care is transferred to a PCP, both the PCP and the patient should be informed of the appropriate follow-up and management strategy. This approach will necessitate re-referral for oncology assessment if a patient is receiving adjuvant endocrine therapy.

Breast Cancer Surveillance Testing—Not Recommended		
FDG-PET Scanning	Not included in previous update.	FDG-PET scanning is not recommended for routine breast cancer surveillance. *2006 Literature Update and Discussion:* While FDG-PET scanning may demonstrate more sensitivity than conventional imaging in diagnosing recurrent disease, there is no evidence that there is an impact on survival, quality of life, or cost-effectiveness.
Breast Magnetic Resonance Imaging (MRI)	Not included in previous update.	Breast MRI is not recommended for routine breast cancer surveillance. *2006 Literature Update and Discussion:* While screening breast MRI appears to be more sensitive than conventional imaging at detecting breast cancer in high risk women, there is no evidence that breast MRI improves outcomes when used as a breast cancer surveillance tool during routine follow-up in asymptomatic patients. The decision to use breast MRI in high-risk patients should be made on an individual basis depending upon the complexity of the clinical scenario.

This table is derived from recommendations in the 2006 Update of the Breast Cancer Follow-Up and Management Guideline in the Adjuvant Setting. This table is a practice tool based on ASCO® practice guidelines and is not intended to substitute for the independent professional judgment of the treating physician. Practice guidelines do not account for individual variation among patients. This tool does not purport to suggest any particular course of medical treatment. Use of the practice guidelines and this table are voluntary. The practice guideline and additional information is available at http://www.asco.org/guidelines/breastfollowup.