Nccn breast cancer screening and diagnosis guidelines

Increased Risk Screening for Breast Cancer

Prior thoracic radiation therapy between the ages of 10 and 30 years	Age <25	• Annual CBE beginning 8 to 10 years after radiation therapy • Breast awareness
	Age >25	• Annual screening mammogram + CBE every 6 to 12 months beginning 8 to 10 years after radiation therapy or at age 40 whichever comes first • Recommend breast MRI • Breast awareness

NCCN, 2014

BREAST AND OVARIAN MANAGEMENT BASED ON GENETIC TEST RESULTS[a]

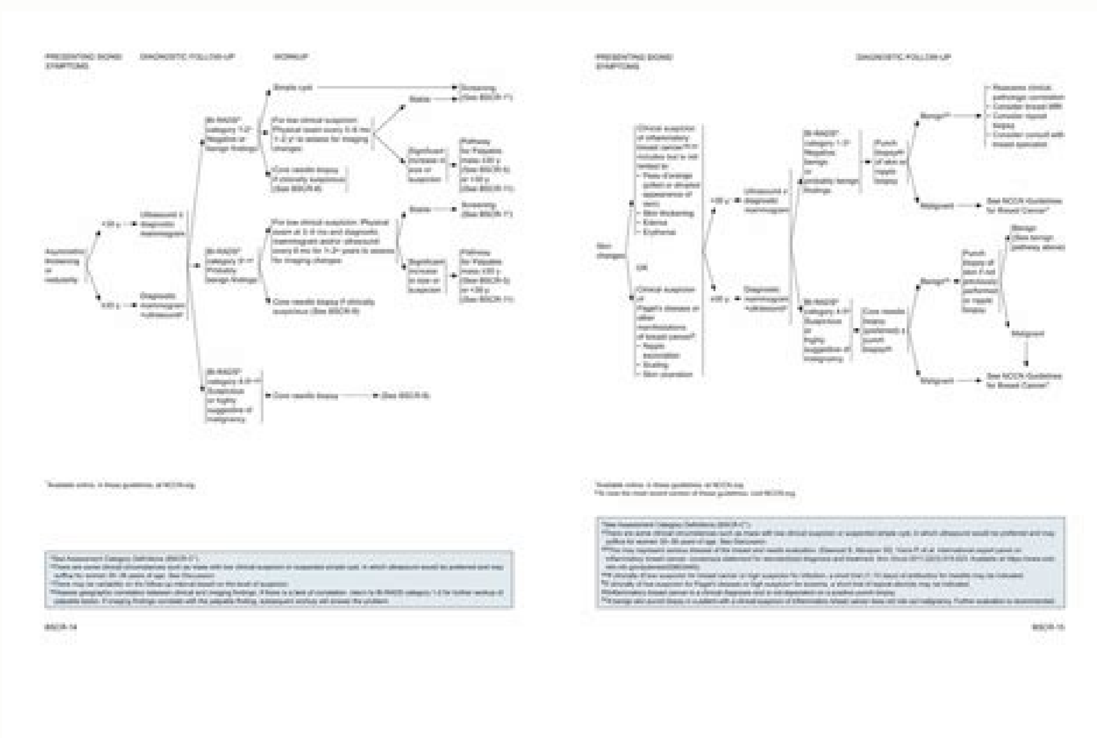
The inclusion of a gene on this table below does not imply the endorsement either for or against multi-gene testing for moderate-penetrance genes.

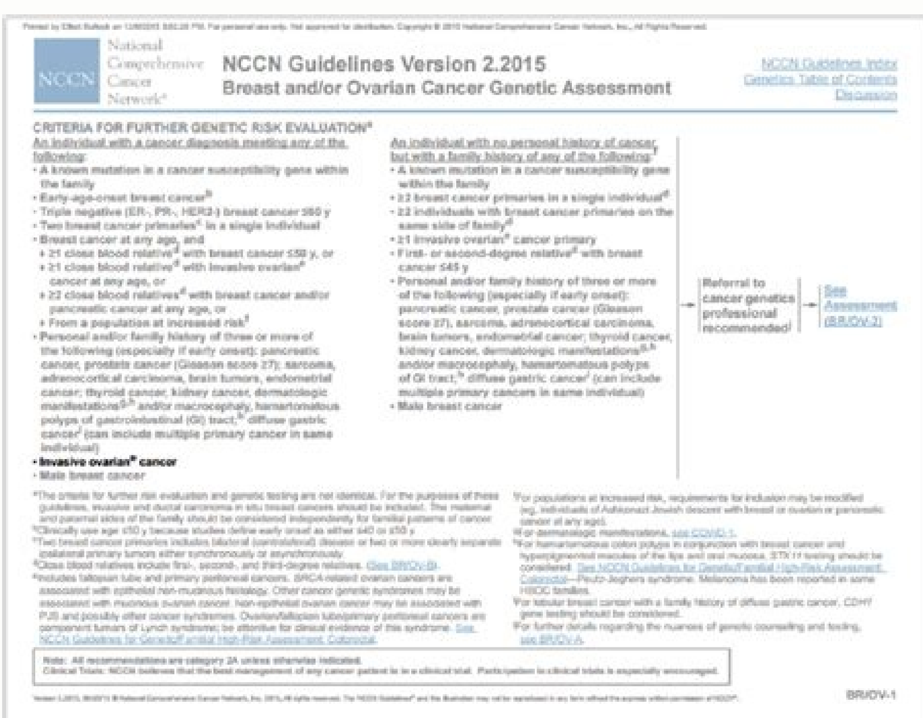
Gene	Breast Cancer Risk and Management	Ovarian Cancer Risk and Management	Other Cancer Risks and Management
PALB2	**Increased risk of BC** • Screening: Annual mammogram and consider breast MRI with contrast at 30 y • RRM: Consider based on family history.	**Unknown or insufficient evidence for OC risk**	Unknown or insufficient evidence
	Comments: Counsel for risk of autosomal recessive condition in offspring.		
PTEN	**Increased risk of BC** • See Cowden Syndrome Management	**No increased risk of OC**	See Cowden Syndrome Management
RAD51C	**Unknown or insufficient evidence for BC risk**	**Increased risk of OC** • Consider RRSO at 45–50 y	N/A
	Comments: Counsel for risk of autosomal recessive condition in offspring. Based on estimates from available studies, the lifetime risk of ovarian cancer in carriers of mutations in *RAD51C* appears to be sufficient to justify consideration of RRSO. The current evidence is insufficient to make a firm recommendation as to the optimal age for this procedure. Based on the current, limited evidence base, a discussion about surgery should be held around age 45–50 y or earlier based on a specific family history of an earlier onset ovarian cancer.		
RAD51D	**Unknown or insufficient evidence for BC risk**	**Increased risk of OC** • Consider RRSO at 45–50 y	N/A
	Comments: Based on estimates from available studies, the lifetime risk of ovarian cancer in carriers of mutations in *RAD51D* appears to be sufficient to justify consideration of RRSO. The current evidence is insufficient to make a firm recommendation as to the optimal age for this procedure. Based on the current, limited evidence base, a discussion about surgery should be held around age 45–50 y or earlier based on a specific family history of an earlier onset ovarian cancer.		
STK11	**Increased risk of BC** • Screening: See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal • RRM: Evidence insufficient, manage based on family history.	**Increased risk of non-epithelial OC** • See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal	See NCCN Guidelines for Genetic/Familial High-Risk Assessment: Colorectal
TP53	**Increased risk of BC** • See Li-Fraumeni Syndrome Management	**No increased risk of OC**	See Li-Fraumeni Syndrome Management

[a]Tung N, Domchek SM, Stadler Z, Nathanson KL, Couch F, Garber JE, Offit K, Robson ME. Counselling framework for moderate-penetrance cancer-susceptibility mutations. Nat Rev Clin Oncol 2016;13:581-588.

BC: Breast cancer
OC: Ovarian cancer
RRM: Risk-reducing mastectomy
RRSO: Risk-reducing salpingo-oophorectomy

GENE-4




NCCN Guidelines Version 2.2015
Breast and/or Ovarian Cancer Genetic Assessment

CRITERIA FOR FURTHER GENETIC RISK EVALUATION

BR/OV-1

TABLE 28.2

NCCN Clinical Practice Guidelines In Oncology (NCCN Guidelines®) for Management of BRCA1/2 Carriers

Women

- Breast awareness starting at age 18 y
- Clinical breast examination, every 6–12 mo, starting at age 25 y
- Breast screening
  - Age 25–29 y, annual breast magnetic resonance imaging (MRI) screening (preferred) or mammogram if MRI is unavailable or individualized based on earliest age of onset in family.
  - Age ≥30–75 y, annual mammogram and breast MRI screening.
  - Age >75 y, management should be considered on an individual basis.
- Discuss option of risk-reducing mastectomy and counsel regarding degree of protection, reconstruction options, and risks
- Recommend risk-reducing salpingo-oophorectomy, ideally between 35 and 40 y and upon completion of childbearing, or individualized based on earliest age at onset of ovarian cancer in the family; counseling includes a discussion of reproductive desires, extent of cancer risk, degree of protection for breast and ovarian cancer, management of menopausal symptoms, possible short-term hormone replacement therapy to a recommended maximum age at natural menopause, and related medical issues
- Address psychosocial, social, and quality-of-life aspects of undergoing risk-reducing mastectomy and/or salpingo-oophorectomy.
- For those patients who have not elected risk-reducing salpingo-oophorectomy, consider concurrent transvaginal ultrasound (preferably days 1–10 of menstrual cycle in premenopausal women) and CA-125 (preferably after day 5 of menstrual cycle in premenopausal women), every 6 mo starting at age 30 y or 5–10 y before the earliest age at first diagnosis of ovarian cancer in the family
- Consider chemoprevention options for breast and ovarian cancer, including discussing risks and benefits
- Consider investigational imaging and screening studies, when available (e.g., novel imaging technologies and more frequent screening interval[s] in the context of a clinical trial)

Men

- Breast self-examination training and education starting at the age of 35 y
- Clinical breast examination, every 6–12 mo, starting at the age of 35 y
- Consider baseline mammogram at the age of 40 y; annual mammogram if gynecomastia or parenchymal/glandular breast density on baseline study
- Starting at age 40:
  - Recommend prostate cancer screening for *BRCA2* carriers
  - Consider prostate cancer screening for *BRCA1* carriers

Breast nccn guidelines. Latest nccn guidelines for breast cancer. Breast cancer nccn guidelines 2020. Nccn guidelines version 1.2021 breast cancer screening and diagnosis. Nccn breast screening guidelines. Nccn clinical practice guidelines in oncology breast cancer screening and diagnosis. Nccn guidelines version 1.2019 breast cancer screening and diagnosis.

Mammography is a special type of low-dose x-ray imaging used to create detailed images of the breast. Mammography is currently the best available population-based method to detect breast cancer at an early stage, when treatment is most effective. Mammography can demonstrate microcalcifications smaller than 100 µm; it often reveals lesions before they become palpable by clinical breast examination (CBE) and, on average, 1-2 years before being found by breast self-examination (BSE). An estimated 48 million mammograms are performed each year in the United States. The US Preventive Services Task Force (USPSTF) estimates the benefit of mammography in women aged 50-74 years to be a 30% reduction in risk of death from breast cancer. For women aged 40-49 years, the risk of death is decreased by 17%. There are 2 types of mammography examinations: screening and diagnostic. Screening mammography is done in asymptomatic women. Diagnostic mammography is performed in symptomatic women (eg, when a breast lump or nipple discharge is found during self-examination or an abnormality is found during screening mammography). This examination is more involved, time-consuming, and expensive than screening mammography and is used to determine the exact size and location of breast abnormalities and to image the surrounding tissue and lymph nodes. Women with breast implants or a personal history of breast cancer will usually require the additional views used in diagnostic mammography. The American College of Radiology (ACR) has established the Breast Imaging Reporting and Data System (BI-RADS) to guide the breast cancer diagnostic routine. BI-RADS is the product of a collaborative effort between members of various committees of the ACR in cooperation with the National Cancer Institute (NCI), the Centers for Disease Control and Prevention (CDC), the FDA, the American Medical Association (AMA), the American College of Surgeons (ACS), and the College of American Pathologists (CAP). [12] The BI-RADS system includes categories or levels that are used to standardize interpretation of mammograms among radiologists. For referring physicians, the BI-RADS categories indicate the patient’s risk of malignancy and recommend a specific course of action. Of all of the screening mammograms performed annually, approximately 90% show no evidence of cancer. On necessary further diagnostic testing, approximately 2% of all screening mammograms are shown to be abnormal and require biopsy. Among cases referred for biopsy, approximately 80% of the abnormalities are shown to be benign, and 20% are shown to be cancerous. See Mammography in Breast Cancer for more information. Mammographic sensitivity for breast cancer declines significantly with increasing breast density, and the risk of breast cancer is higher in women with dense breasts. Hormonal status has no significant effect on the effectiveness of screening independent of breast density. Although mammography remains the most cost-effective approach for breast cancer screening, it is far from a perfect screening test. The accuracy of screening mammography increases with increasing patient age, in tandem with the increasing incidence of breast cancer. Mammography has a sensitivity of 76.5% and a specificity of 87.1% for women younger than 40 years. [13] By comparison, in women 50 to 59 years old, the sensitivity of screening mammography is 77.3% and the specificity is 98.7%. [14] In women older than 80 years, mammography has a sensitivity of 86% and a specificity of 94%. [15] A retrospective trend analysis compared rates of breast cancer mortality in pairs of neighboring European countries where mammography screening had been implemented at different times. Findings suggest that mammography screening has little detectable impact on mortality due to breast cancer. [16] Mammography uses low-dose ionizing radiation, which may be harmful to the patient. Nevertheless, the benefits of mammography far outweigh the risks and inconvenience. False-positive results may arise when benign microcalcifications are regarded as malignant. Tissue summation shadows may appear as local parenchymal distortion; this may erroneously be called malignant tissue. A benign, circumscribed lesion may show signs suggestive of malignancy, along with other findings, such as an irregular border and no halo sign. In the United States, approximately 9.5% of screening mammograms yield false-positive results; of US women screened annually for 10 years, approximately 50% will experience a false positive, and 7-17% of those will undergo breast biopsies. [17] False positives occur most commonly with first mammograms; when prior mammograms are available for comparison, the likelihood of a false positive decreases by about 50%. [18] False-negative rates of screening mammography (ie, cases in which invasive breast cancer is present but undetected by mammography) range from 6% to 46%. [17] Possible causes for missed breast cancers include the following: Dense parenchyma obscuring a lesion Poor positioning or technique Perception error Incorrect interpretation of a suspect finding Subtle features of malignancy Slow growth of a lesion Birdwell et al performed a multicenter study and found that on previous mammograms with missed cancers, 30% of the 115 lesions were calcifications, with 49% (17 of 35) clustered or pleomorphic. [19] Approximately 70% were mass lesions, with 40% spiculated or irregular. For calcifications and masses, the most frequently suggested reasons for possible miss were dense breasts (34%) and distracting lesions (44%). Some cancers (eg, mucinous carcinomas) may have well-defined borders and mammographic features suggestive of a benign lesion. A ductogram, or galactogram, is sometimes helpful for determining the cause of nipple discharge. In this specialized examination, a fine plastic tube is placed into the opening of the duct in the nipple. A small amount of contrast medium is injected, which outlines the shape of the duct on a mammogram, and shows whether a mass is present inside the duct. Women with breasts augmented by implants may pose a special challenge. Specific 4-view mammograms may be performed to evaluate the breasts; MRI may be especially useful for detecting breast cancer and silicon implant rupture in this group of patients. See Postsurgical Breast Imaging for more information. News | Mammography | July 28, 2022 SBI 2023 Call for Abstracts is Now Open August 9, 2022 — SBI is pleased to invite all members and nonmembers to submit original abstracts for presentation at ... August 11, 2022 August 10, 2022 — TransMed7, LLC announced that the first clinical cases of the final commercial production version of ... August 10, 2022 July 28, 2022 — According to ARRS’ American Journal of Roentgenology (AJR), for patients with multiple architectural ... 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July 19, 2022 Feature | Breast Imaging | By Christine Book In a detailed overview held during the Radiological Society of North America’s (RSNA) 2021 annual meeting, promising ... July 08, 2022 June 28, 2022 — Mindray, a global leader and developer of healthcare technologies and solutions for ultrasound, patient ... June 28, 2022 Subscribe Now The free evidence-based, expert consensus resource, available at NCCN.org/patientguidelines, helps people ask the right questions about when and how often to screen. PLYMOUTH MEETING, Pa., July 27, 2022 /PRNewswire/ -- The National Comprehensive Cancer Network® (NCCN®) has published new NCCN Guidelines for Patients®: Breast Cancer Screening and Diagnosis to help people understand their personal risk for breast cancer, when they should begin screening, and how often to screen—in order to detect cancer earlier, for more treatment options and better outcomes. With this information, they are equipped to have more informed conversations with their health care providers and be active decision-makers in their long-term health. Continue Reading The breast cancer screening guidelines are the latest in NCCN's library of NCCN Guidelines for Patients®, published through funding from the NCCN Foundation® and available for free at NCCN.org/patientguidelines and via the NCCN Patient Guides for Cancer App. NCCN Guidelines for Patients provide information on nearly 60 cancer types, as well as topics such as treatment side effects, distress management, and survivorship. "There are many, often conflicting, recommendations surrounding breast cancer screening, which causes a lot of confusion and apprehension," said Therese Bevers, M.D., Professor of Clinical Cancer Prevention, The University of Texas MD Anderson Cancer Center; Chair, NCCN Guidelines Panel for Breast Cancer Screening and Diagnosis. "These are the latest, evidence-based guidelines from experts in the field of breast cancer screening and diagnosis from more than two dozen leading cancer centers in the United States." "Everyone with breasts carries some risk of breast cancer, so the key is to know your risk," said Dr. Bevers. "Most women with average risk should get screened every year, beginning at age 40, but if there are additional risk factors present, a provider might recommend an earlier start." According to the guidelines, women should undergo a risk assessment for developing breast cancer starting at age 25. Increased risk is based on a number of factors including age and family history of certain cancers—including ovarian and pancreatic cancer, not just breast cancer.And regular screening and breast exams are safe and important for those who are pregnant or breastfeeding, Dr. Bevers added. "A lot of women think they need to put this on hold, but we can shield the belly, and the radiation is very low dose and targeted. It's important to keep up with screenings. Especially for women whose first pregnancy is happening when they are 40 or older.""Annual mammography screening beginning at age 40 is associated with the highest mortality reduction for average risk women," said Mark Helvie, MD, Professor, Active Emeritus, Department of Radiology, University of Michigan; Member, NCCN Guidelines Panel for Breast Cancer Screening and Diagnosis. "Regular screening and breast exams help find breast cancer at its earliest, most treatable stages. Having a mammogram at infrequent or irregular intervals limits its effectiveness. For women at increased risk, the NCCN Guidelines recommend starting screening earlier and often include breast MRI in addition to mammography."The NCCN Guidelines for Patients: Breast Cancer Screening and Diagnosis also addresses the appropriate evaluation of breast symptoms most-commonly seen as a palpable lump, pain, or nipple discharge—though anything at all unusual with the breasts should be discussed with a doctor. Cancer symptoms can be similar to symptoms from benign causes and they can also occur in unique ways. Therefore, if a provider or patient discovers anything out of the ordinary, the NCCN Guidelines recommend a prompt clinical and diagnostic check with imaging and, in some cases, biopsy to determine the correct diagnosis."These guidelines will help so many people," said Sue Friedman, DVM, Executive Director, Facing Our Risk of Cancer Empowered. "There is general confusion about breast cancer screening guidelines and what screening people should follow based on their risk. NCCN patient guidelines are an easy way for people to access up-to-date expert recommendations in plain language."NCCN Guidelines for Patients are based on the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®), which are updated frequently by multidisciplinary teams of experts from across NCCN Member Institutions. The patient versions present unbiased expert guidance in an easy-to-read format—with clear language, charts, images, and a glossary of medical terms.Patient guidelines are also available for colorectal cancer screening and lung cancer screening, Learn more at NCCN.org/patients.About the National Comprehensive Cancer NetworkThe National Comprehensive Cancer Network® (NCCN®) is a not-for-profit alliance of leading cancer centers devoted to patient care, research, and education. NCCN is dedicated to improving and facilitating quality, effective, equitable, and accessible cancer care so all patients can live better lives. The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) provide transparent, evidence-based, expert consensus recommendations for cancer treatment, prevention, and supportive services; they are the recognized standard for clinical direction and policy in cancer management and the most thorough and frequently-updated clinical practice guidelines available in any area of medicine. The NCCN Guidelines for Patients® provide expert cancer treatment information to inform and empower patients and caregivers, through support from the NCCN Foundation®. NCCN also advances continuing education, global initiatives, policy, and research collaboration and publication in oncology. Visit NCCN.org for more information and follow NCCN on Facebook @NCCNorg, Instagram @NCCNorg, and Twitter @NCCN.About the NCCN FoundationThe NCCN Foundation® was founded by the National Comprehensive Cancer Network® (NCCN®) to empower people with cancer and advance oncology innovation. The NCCN Foundation empowers people with cancer and their caregivers by delivering unbiased expert guidance from the world's leading cancer experts through the library of NCCN Guidelines for Patients® and other patient education resources. The NCCN Foundation is also committed to advancing cancer treatment by funding the nation's promising young investigators at the forefront of cancer research. For more information about the NCCN Foundation, visit NCCN.org/foundation.Media Contact: Rachel Darwin267-622-6624SOURCE National Comprehensive Cancer Network

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