



Impact of Collaborative Evidence-Based Breast Cancer Survivorship Care Guidelines on Survivors and Providers

Erin Hartnett, DNP, APRN-BC, CPNP

Breast cancer survivors face many challenges stemming from both their disease and its treatment. In December 2015, the American Cancer Society and the American Society of Clinical Oncology released collaborative evidence-based breast cancer survivorship care guidelines for female breast cancer survivors and their primary care providers. This article discusses these recommendations for surveillance, screening, and management of both long-term and late effects of breast cancer and treatment.

At a Glance

- The American Cancer Society and the American Society of Clinical Oncology (ASCO) collaborative breast cancer survivorship care guidelines are based on previous recommendations from ASCO and the National Comprehensive Cancer Network.
- These guidelines contain holistic recommendations to help with the surveillance and management of both long-term and late effects of breast cancer and treatment.
- Nurses need to provide information, education, and support to assist women with following these guidelines after treatment for breast cancer.

Erin Hartnett, DNP, APRN-BC, CPNP, is the program director of Oral Health Nursing Education and Practice and Teaching Oral Systemic Health in the College of Nursing at New York University in New York. The author takes full responsibility for the content of the article. The author did not receive honoraria for this work. No financial relationships relevant to the content of this article have been disclosed by the author or editorial staff. Mention of specific products and opinions related to those products do not indicate or imply endorsement by the *Clinical Journal of Oncology Nursing* or the Oncology Nursing Society. Hartnett can be reached at hartne01@nyu.edu, with copy to editor at CJONEditor@ons.org.

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Many of the 3.1 million breast cancer survivors in the United States (American Cancer Society [ACS], 2014; Siegel, Miller, & Jemal, 2015) face challenges related to both their cancer and its treatment, and they require follow-up care. In December 2015, the ACS and the American Society of Clinical Oncology (ASCO) released collaborative evidence-based breast cancer survivorship care guidelines for female breast cancer survivors and their primary care providers (PCPs) (Runowicz et al., 2016). These guidelines, based on previous recommendations from ASCO and the National Comprehensive Cancer Network, contain holistic recommenda-

tions to help PCPs with the surveillance and management of both long-term and late effects to improve overall health and quality of life (Simon, 2015). The risk of long-term and late effects after breast cancer treatment depends on the type of treatment, duration of treatment, dose of drug, and age of the patient (Runowicz et al., 2016). Long-term effects develop during treatment, whereas late effects appear months or years after treatment. Clinical follow-up care for survivors needs to be individualized based on age, diagnosis, and treatment protocol as recommended by the oncology team. Ideally, oncologists should provide patients and PCPs with a treatment summary or survivorship care

plan to highlight the possible late effects that may result from a specific treatment. Samples of survivorship care plans are available online (<http://bit.ly/1zePTXd>). Figure 1 describes the five areas of focus of the ACS/ASCO guidelines.

Surveillance for Breast Cancer Recurrence or New Primary Cancer

Recommendations include a physical examination every 3–6 months for the first three years after primary therapy, followed by every 6–12 months for the next two years and then annually (Runowicz et al., 2016). Annual mammograms are the only required testing. For women with unilateral mastectomy, annual mammography on the intact breast is recommended, whereas annual mammography of both breasts is recommended for those with lumpectomies (Runowicz et al., 2016). Advanced imaging and routine laboratory testing with tumor markers is not recommended (Henry et al., 2014). Providers must educate patients to be aware of any breast or chest wall changes (e.g., rash, skin changes, pain) that may indicate local or regional recurrence, and survivors should be encouraged to continue anti-estrogen therapy as prescribed by their oncologist. This therapy, which may continue for 5–10 years, has demonstrated reduced risk of recurrence of secondary breast cancers and improved overall survival for estrogen receptor-positive breast cancers (Runowicz et al., 2016). PCPs also should review family history at frequent intervals; any new cancers in the family may increase the survivor's risk profile. Genetic counseling should be suggested if potential hereditary risk factors are suspected (Runowicz et al., 2016).