Managing Families With a Hereditary Cancer Syndrome

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Oncology is one of the first subspecialties to experience the full impact of the genomics revolution; oncology nurses regularly use genomic science in prevention, screening, diagnostics, prognostics, selection of treatment, and monitoring of treatment effectiveness in cancer care (Mahon, 2009). Genetic tests are now routinely ordered to determine risk for developing and appropriate management of hereditary breast and ovarian cancer, hereditary nonpolyposis colorectal cancer, and many other hereditary cancer syndromes—often without formal genetic assessment by a credentialed professional. Two cases will be reviewed that demonstrate the complexities of providing and coordinating care for at-risk relatives with a genetic predisposition to developing cancer.

Case Study 1

The first case illustrates the potential positive aspects that can occur when a family with suspected hereditary predisposition is managed by a credentialed genetics professional.

A 39-year-old woman was diagnosed with colorectal cancer after an episode of rectal bleeding. The colorectal surgeon appropriately referred her for genetic counseling based on her young age of onset. A pedigree was constructed. The proband’s (i.e., patient’s) mother died from pancreatic cancer and one great paternal aunt died a year later. The oncologist had learned that she had already had genetic testing and was known to have the same mutation; she was subsequently found to have metastatic breast cancer at the time of her prophylactic mastectomy, two months after her sister (the proband) was diagnosed. The proband’s brother also had a mutation; the mutation was not de novo. Next, the mother was offered testing for the specific mutation and she tested negative. The father was offered testing and found to be the carrier. At the time of testing, he was clearly informed that if he tested positive, he had an ethical obligation to contact his siblings, even if they were estranged, and inform them of the possible increased risk. He tested positive and subsequently contacted his 56-year-old sister. After discussion, he learned that she had already had genetic testing and was known to have the same mutation. It had been done through her oncologist five years earlier.

The proband was devastated because, had she known she had the increased risk, she would have considered prophylactic measures; she subsequently died a year later. The oncologist had correctly ordered the testing and recommended prophylactic surgery (bilateral mastectomy and oophorectomy) for the 56-year-old paternal aunt of the proband. Of great concern, however, was that none of the other siblings of this aunt seemed aware of their risk or had undergone testing. The genetics professional provided counseling and testing for the other four siblings, and three tested positive. They have since undergone appropriate prophylactic measures and testing is now being coordinated for their offspring as they become old enough to consider testing.

Commentary on the Cases

Case 1 clearly illustrates the importance and complexity of genetic testing. First, genetic testing is continually evolving. A family who has previously tested negative for common mutations should be offered testing as new mutations are identified; this is a regular component of the practice of genetics.