

COVID-19 Advice to GPs



Assessment of breast problems during COVID 19 Pandemic

The COVID-19 pandemic poses significant challenges for new and existing patients, GPs, specialists, radiologists and health care systems. Face to face contact has to be minimised and intervention should be used sparingly to preserve personal protective equipment and relieve the burden on our hospitals and health care workers.

The following recommendations have been devised to assist GPs triage, assess and manage breast patients during this crisis.

The recommendations have been collaboratively developed by Cabrini Health and Monash Health breast surgeons and are informed by advice from BreastSurgANZ and Department of Health and Human Services as at 10 April 2020.

Four groups of patients with examples are described:

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1 Symptomatic patients

Emergency - clinically unstable

Breast abscess or haematoma.

If untreated patient is at risk of sepsis, haemodynamic shock and/or skin necrosis.

Recommend urgent surgical referral for drainage, either image guided or surgical.

Urgent - Non-critical but delay beyond three months could potentially impact overall outcome.

Clinically suspicious breast or axillary lump, distortion, peau d'orange.

Investigate with diagnostic mammogram, tomosynthesis and targeted ultrasound. If suspicious or malignant imaging findings (Table 1: BIRADS 4B, 4C and 5) or remains highly clinically suspicious despite negative imaging, patient will need prompt surgical referral for further assessment and image guided biopsy. Whilst a diagnosis of cancer is likely, the management will depend on the tumour biology, volume of disease, patient's age and co-morbidities. Multidisciplinary team meetings will continue during the pandemic. The clinical risk to the patient will vary depending on the tumour phenotype and neoadjuvant therapy may be initiated with drugs (including endocrine therapy) before surgery is scheduled. Immediate breast reconstruction is currently suspended, as it has no impact on overall survival.

Post-operative patient with infected seroma.

Recommend prompt referral back to the treating surgeon or team for percutaneous aspiration, culture and antibiotic therapy.

Non urgent - Stable condition unlikely to cause significant harm with six month delay.

New, clinically benign or equivocal breast lump, nipple discharge.

Investigate with diagnostic mammogram, tomosynthesis (if over 35 years) and targeted ultrasound. Palpable lesions with equivocal or suspicious imaging findings (Table 1: BIRADS 4), will need surgical referral for further assessment. These patients will typically be suitable for specialist telehealth consult and decision making. An observation policy is likely with follow up imaging of equivocal lesions over three to six months, rather than an image guided biopsy.

If benign findings (Table 1: BIRADS 2 and 3) eg fibroadenoma, fibrocystic change, breast cyst or mammary duct ectasia, reassure patient and offer GP clinical breast examination in six months.

Known patient with multiple fibroadenomas, cysts or fibrocystic change.

In absence of new findings, do not refer for diagnostic imaging. If there is clinical concern organise a targeted ultrasound. Symptomatic cysts often settle after weeks without aspiration. Reassure patient that these conditions are benign. Offer GP clinical examination in six months.

Mastalgia

In absence of other findings, do not refer for diagnostic imaging. Premenopausal women will typically have cyclical mastalgia, postmenopausal women typically have chest wall (musculoskeletal) pain. Consider the possibility of cardiorespiratory causes. Offer GP clinical examination in six months.

2 Asymptomatic patients

Average or Moderate Increased Population Risk Screening

Routine screening can be deferred until the COVID-19 pandemic resolves. It is reasonable for patients in the general population to defer screening mammography for six to twelve months, a delay that is not likely to have an impact on overall survival. BreastScreen Australia has suspended its screening service for the immediate future and plans to resume services once the threat of COVID 19 diminishes to a low risk. In the process of suspending screening, the BIRADS 3 lesions were read by two further radiologists and the vast majority were cleared.

High Risk Screening (Confirmed gene mutation carriers, strong family history, ADH).

Most of these patients are under the care of a breast specialist or service. It is probably safe to defer screening for six months. Medical prevention with tamoxifen should be considered as it offers a 40% risk reduction in the diagnosis of breast cancer. Patients must not get pregnant on tamoxifen. Patients under 50 with a confirmed hereditary predisposition to breast cancer (BRCA 1 and BRCA 2 gene carriers) are of more concern and imaging with a single modality eg MRI may be reasonable. Risk reducing mastectomies are currently suspended.

3 Patients with LOW RISK and indeterminate lesions

Patients with biopsy proven low and intermediate grade DCIS, lobular neoplasia, ADH, complex sclerosing lesions and intraduct papillomas are usually asymptomatic and screen detected. Surgery for these conditions is currently suspended as they are considered non urgent and unlikely to cause significant harm with a six month delay. Please ensure these patients have a treating surgeon.

Impalpable BIRADS 3 (probably benign) lesions have a <2% likelihood of malignancy. BIRADS 4A (Low suspicion for malignancy) have a 2-10% chance of malignancy (Table 1). These incidental lesions should be discussed with the reporting radiologist, or the radiologist in the group with subspecialist

breast expertise. Review of these impalpable lesions and consideration of double reporting will often lead to a more definitive assessment, and appropriate reassurance of women without surgical referral.

4 Breast Cancer and dcis Patients under Surveillance and Shared Care

Most of these patients are under the care of a breast specialist or service. For low and high risk asymptomatic patients, surveillance imaging can be safely deferred until the COVID-19 pandemic resolves. Symptomatic patients need to be assessed and investigated accordingly.

Table 1: ACR BIRADS Classification for Breast Imaging with Mammogram, Ultrasound and MRI.

Radiological reporting is variable, but many radiologists will reference the BIRADS classification to predict likelihood of malignancy (Table 1). Some lesions are **equivocal** (BIRADS Categories 3 and 4A) and in this context a second radiologist opinion may omit the necessity for intervention and a core biopsy.

Assessment	Management	Likelihood of Cancer
Category 0: Incomplete – Need Additional Imaging Evaluation and/or Prior Mammograms for Comparison	Recall for additional imaging and/or comparison with prior examination(s)	Not applicable
Category 1: Negative	Routine mammography screening	Essentially 0% likelihood of malignancy
Category 2: Benign	Routine mammography screening	Essentially 0% likelihood of malignancy
Category 3: Probably Benign	Short interval (6 month) Follow up or continued surveillance mammography	> 0% but ≤ 2% likelihood of malignancy
Category 4: Suspicious Category 4A: Low suspicion for malignancy Category 4B: Moderate suspicion for malignancy Category 4C: High suspicion for malignancy	Tissue diagnosis	> 2% but < 95% likelihood of malignancy > 2% to ≤ 10% likelihood of malignancy > 10% to ≤ 50% likelihood of malignancy > 50% to < 95% likelihood of malignancy
Category 5: Highly Suggestive of Malignancy	Tissue diagnosis	≥ 95% likelihood of malignancy
Category 6: Known Biopsy-Proven Malignancy	Surgical excision when clinically appropriate	Not applicable