This piece is intended to educate physicians on the clinical utility of the Onco
type DX Breast Cancer Assay and should not be provided to patients.

**References**

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**Feedback**

This is our 17th issue of Nursing Network News and we’d love to know what you think. Please email nursingnetwork@breastcancercare.org.uk

**Your views**

We’re also looking for contributions for future issues. If you’d like to write an article or have an idea you’d like to share with network members, please get in touch using the above email.

**Contents**

**News**

4 A view from... Samia al Qadhi, Chief Executive at Breast Cancer Care talks about our plans to support even more people affected by breast cancer

5 Highlights from 2015 Emily Snelling, Press and PR Manager shares some of our highlights with you

6 General election 2015 Andy Glyde, Campaign Manager at Breast Cancer Care shares our manifesto for the General Election and how you can support our calls to action

8 Fundraising focus: Pink Ribbonwalks Nursing Network member Jacky Docherty explains why she took part in our 2014 Pink Ribbonwalks

**Sharing practice**

10 Management of the axilla in breast cancer Miss Fiona MacNeill, Consultant Breast Surgeon at The Royal Marsden NHS Foundation Trust gives us an update on the topical subject on the management of the axilla

12 Conference report: San Antonio Breast Cancer Symposium 2014 We reflect on key Symposium presentation that could have an impact on UK practice and care

**Services for patients**

22 Service profile: PROWESS We tell you more about our pilot supportive self-management programme designed for those that have finished their initial hospital-based treatment

**Learning together**

18 The Nursing Network and professional development opportunities Find out how our new jam-packed professional development calendar can support you and your team throughout 2015

21 Resources update: Benign breast conditions Jackie Harris, CNS at Breast Cancer Care tells us more about our popular series of patient information

**About Breast Cancer Care**

Breast Cancer Care is the only UK-wide charity providing specialist support and tailored information for anyone affected by breast cancer.

**Editorial board**

Dr Emma Pennery, Clinical Director; Emily Codins, Editor; Jan Hannell, Healthcare Professional Events Manager.
A view from ...

Samia al Qadhi, Chief Executive at Breast Cancer Care, tells us more about the recently announced merger between Breakthrough Breast Cancer and Breast Cancer Campaign and how we plan to support even more people affected by breast cancer.

You may have heard that Breakthrough Breast Cancer and Breast Cancer Campaign are merging. In 2013 both charities published strategies with very similar aims. The two charities agreed that by merging they will be able to achieve these aims sooner and be able to increase research into treating and preventing breast cancer. The new charity will come into existence in April 2015.

We believe both research into treating and preventing breast cancer and support for people affected by breast cancer are essential. However we want to do more. We want to make sure that every person affected by breast cancer receives the best treatment, information and support and to help them find a way to live with, through and beyond breast cancer. Our work with healthcare professionals, such as yourselves, is crucial in achieving this. We know the difference a skilled breast care nurse can make, so our Nursing Network remains one of our priorities.

Our work with healthcare professionals, such as ourselves, is crucial in achieving this. We know the difference a skilled breast care nurse can make, so the Nursing Network remains one of our priorities. By sharing practice, learning together and driving change through the clinical setting we can make a difference to patient care. Thank you for working with us and all you do for your patients.

For more information on how we can support you and your patient visit www.breastcancercare.org.uk

Highlights from 2014

2014 was another bumper year for Breast Cancer Care. Emily Snelling, Press and PR Manager shares some of our highlights with you.

Pass it on

The Football Association (FA) has become official charity partnership with Breast Cancer Care for 2014-16. Over the next two years, the partnership will reach thousands more people across the country with our vital breast health awareness message and aims to raise an incredible £500,000.

Sky Sports presenter and Breast Cancer Care supporter Jacqui Beltrao, said:

‘Having had my own devastating diagnosis and also losing my aunt to breast cancer, I know first-hand that this brutal disease can shatter lives. It’s really important that everyone knows the changes to look and feel for when checking their breasts.’

Tickled Pink

Asda’s Tickled Pink has been raising money for Breast Cancer Care for the last 17 years and has raised £40 million so far.

Breast Cancer Care worked in partnership with Asda’s George clothing range to create its first post-surgery underwear, swimwear and headscarf range which is available through their website year round.

Body confidence win

Breast Cancer Care won the Dove Self Esteem Award for our body image after breast cancer campaign at The Body Confidence Awards.

This campaign raised awareness about the impact breast cancer can have on body image. Breast Cancer Care Trustee, Deborah Rozansky said:

‘Taking part in this campaign was an important decision for each of our three models. Jill, Heather and Ismena – ordinary people who were not professional models – bared mastectomy scars and their personal feelings about their bodies.’

Two boys – one boat

Luke Birch and Jamie Sparks became the youngest pair to row the Atlantic Ocean and raised over £350,000 for Breast Cancer Care, making them Breast Cancer Care’s biggest ever individual fundraisers.

It took 54 days of non-stop rowing to travel 3,000 nautical miles as part of the Talisker Whisky Atlantic Challenge. The ‘2 Boys in a Boat’ came fifth in the overall race and second in their class of boat.

The boys battled huge waves, 30 knot winds, excruciating salt-sores and had no more than 80 minutes of continuous sleep at one time.

With the incidence of breast cancer increasing, the demand for our services is higher than ever. Last year we helped more than three million people affected by breast cancer. Our free services are designed to complement the care and support you offer your patients. Our face-to-face services, such as Moving Forward, bring people together to share their experiences; our online services and Forums offer around-the-clock support; and our specialist services support patient groups with specific needs such as younger women with breast cancer and those living with metastatic disease. Our free Helpline is here to answer any questions about breast cancer and talk through concerns however big or small.

We want to do more. We want to make sure that every person affected by breast cancer receives the best treatment, information and support and to help them find a way to live with, through and beyond breast cancer.
General Election 2015 – putting breast cancer on the agenda

Andy Glyde, Campaign Manager at Breast Cancer Care shares our Manifesto for the upcoming General Election and how you can support our calls to action.

While the result of the upcoming General Election might be too difficult to predict, one certainty is that the NHS will be one of the hot topics between competing political parties. It continually ranks as one of the most important issues to voters and we can expect health matters to form a cornerstone of speeches, pledges and party manifestos.

Whichever party or parties end up forming the next Government, they will have a fantastic opportunity to make a big difference for the people living with breast cancer today. It needs to be bold and ambitious and commit to improving care.

Breast Cancer Care will be using the election as an opportunity to make sure that the issues faced by people with breast cancer are firmly on the agenda. We will work with MPs and candidates, as well as each of the parties, to make sure our messages are heard. Crucially, we need your help to do this.

The Breast Cancer Manifesto

In February, Breast Cancer Care launched its Manifesto on breast cancer. It contains three key areas that the next Government must make a priority.

The first is on improving secondary breast cancer care. We know that for many of the estimated 36,000 people living with secondary breast cancer, the support they receive is often not as good as the support they received for their primary diagnosis. It is far less likely that they will have a clinical nurse specialist attached to their care. Our research has also found that many are living in pain and are not being referred to a palliative care team. The next Government must also commit to collecting and publishing robust data on secondary breast cancer so that services can be planned and commissioned to meet patient needs.

The second is on fertility care for younger women. We know that too few are being told about how their breast cancer treatment could affect their fertility. 88% are not being referred to a fertility clinic to discuss the possibility of freezing eggs or embryos ahead of treatment. This means that an estimated 5,000 younger breast cancer patients across the UK are missing out on fertility care, despite their treatment potentially leaving them unable to have children in future.

Finally, on body image and intimacy, the next Government must look to ensure that the emotional and psychological needs of patients are met. Addressing body image and intimacy concerns should be a routine part of effective clinical treatment. More needs to be done to assess the psychological needs of patients and people need to be able to access specialist and timely information and support about altered body image and intimacy.

What can you do?

Over the next few months, the candidates in your constituency are likely to be contacting you and canvassing for your votes. This provides a great opportunity to ask them how their party’s health policies could have an impact on people affected by breast cancer. You could ask them specific questions based on our manifesto or simply ask them to campaign for breast cancer if they are elected to Parliament.

Even if you do not see your candidates, you could always write to them. Using our website, you can ask them to commit to improving the care and support that people with breast cancer receive. You could also send them a copy of our Manifesto.

Find out more and get involved at www.breastcancercare.org.uk/election2015
The Pink Ribbonwalks are our biggest fundraising events of the year and in 2014 they raised over £1,000,000. Breast Cancer Nurse and Nursing Network member Jacky Docherty explains why she took part last year.

‘My team and I wanted to give a little back to Breast Cancer Care for the marvellous input they provide for our professional lives and for the ladies we care for, from diagnosis to treatment and beyond. We use the literature which underpins the diagnostic information given at the point of diagnosis which is extremely helpful. We also refer patients onto their free Helpline, the many online forums and their specialist services such as Younger Women Together and Living with Secondary Breast Cancer.

‘However, we had tried, without much success, to gather donations for Breast Cancer Care via donation cardboard money boxes, which we dotted around our unit. Being disappointed that we couldn’t provide a little for all the literature and training we had received over the years we decided to take action ourselves and signed up to do a Pink Ribbonwalk.

‘Two of the nurses and I from the Breast Screening & Diagnostic team entered the walk with my colleague’s sister who signed up to walk with us too. We decided to walk the 10 mile route option but were quite in awe of the 20 mile girls who did fantastically on a very hot day. I have to admit that I found the walk quite challenging as we headed towards the finish line, and the hot sun made it exhausting but it was an incredible day.

‘In order to prepare, my team all trained individually coercing our husbands to join us along the way, and we enjoyed exploring our local areas on sunny evenings and weekends. We found that it was a great way to keep fit and a few pounds were shed by most of us ... which was a welcomed bonus!

‘On the day we were welcomed by the buzz surrounding the event when we met people of all ages who were suited and booted, ready for the walk to begin. Some wore names of loved ones they were dedicating the walk to, which was a lovely reminder of why we were there, and there were hundreds of pink feather boas, glittery hats and most of all wide smiles everywhere.

‘Everyone was so excited to get going and the atmosphere was electric. We left in waves, small groups at a time but soon merged into a swarm of focused fundraisers. After four miles we had a refreshment break and then continued to the end. We were all grateful to cross the finishing line and to have been part of such a wonderful day.

‘We were all astounded by the amount raised and surprised how easy it was. In the end we raised £900 - double our initial expectations. We know this amount would be added to the hundreds and thousands raised by our fellow walkers...definitely worthwhile!’

Stop press! Nursing Network members can save £5 when signing up for one of our Pink Ribbonwalks. Just quote CARE4

Join us on a guided 5, 10 or 20 mile walk in stunning locations and raise money for people living with breast cancer.

Blenheim Palace, Oxfordshire – Saturday 9 May
Scone Palace, Perthshire – Saturday 16 May
Stourhead, Wiltshire – Saturday 6 June
Bakewell, Derbyshire – Saturday 13 June
Leeds Castle, Kent – Saturday 20 June
London at Night – Saturday 4 July

Sign up at www.breastcancercare.org.uk/walk or call 0370 145 0101

Registered charity in England and Wales (1017658) Registered charity in Scotland (SC038104) Registered company in England (2447182) in association with

With T-shirt, post-walk meal, medal and massage!
Management of the axilla in breast cancer

Miss Fiona MacNeill, Consultant Breast Surgeon at The Royal Marsden NHS Foundation Trust gives us an update on the topical subject on the management of the axilla.

Introduction

The role and value of axillary surgery has provoked debate and controversy for many years but never more so than in 2015 where the biology of a cancer, rather than the surgically determined axillary nodal stage and prognosis, now drives a more targeted, effective use of systemic therapies. It’s possible we’re moving (albeit slowly) into an era where breast/axillary surgery may become the ‘adjuvant’ therapy, mopping up residual disease after targeted primary therapies.

With earlier diagnosis and consequent lower disease burden, we have moved away from axillary clearance as a staging procedure: preoperative axillary assessment and sentinel lymph node biopsy (SLNB) now identify women with node positive disease for primary axillary clearance, so allowing the increasing number with node negative disease to avoid more radical axillary surgery. Recently AMAROS, a randomized study of completion clearance or radiotherapy (RT) for SLNB positive disease, demonstrated an equivalent local regional control and survival at six years. The Z11 findings were supported by the IBCSG study, another randomised trial of completion axillary clearance or no further axillary surgery. The study demonstrated that both groups had equivalent local regional control and survival at six years.

Management of the (sentinel) node positive axilla.

Although up to 30% of women with negative axillary assessment will be SLN positive. For the majority the SLN will be the only positive node so that the completion clearance is a technically unnecessary procedure. For those that do have further nodal disease the value of clearance has been strongly challenged by the Z11 and IBCSG studies. The Z11 study randomised women with early, good prognosis (small, grade 1 & 2) breast cancer, having breast conservation and positive SLN (macrometastases) to completion axillary clearance or no further axillary surgery. The study demonstrated that both groups had equivalent local regional control and survival at six years. The Z11 findings were supported by the IBCSG study, another randomised trial of clearance versus no clearance for SLN positive disease (mainly micro-metastatic this time) but also included patients having mastectomy.

What these and other (non-randomised) studies have in common are the remarkably low axillary recurrence rates (1% or less) in patients with node positive disease, in particular in those patients who did not have an axillary clearance but did have additional disease in the remaining nodes. These results have provoked much debate and controversy as it seems counterintuitive that leaving disease in the axilla does not have a detrimental impact. However most women had breast conservation followed by breast RT (30% had some form of lower axillary RT), as well as adjuvant systemic treatments, reinforcing what we already know: adjuvant therapies play a major role in local and systemic disease control.

So how do we use this information to inform our day to day practice?

POSNOC (positive sentinel node: adjuvant therapy alone versus adjuvant therapy plus clearance or axillary radiotherapy), a newly established UK-based randomised controlled study is recruiting strongly, suggesting there remains sufficient uncertainty within many breast MDTs over the utility of clearance in the SLN positive axilla.

If axillary clearance is no longer required for the majority of SLN positive disease, what is the role of highly detailed pathological SLN analysis—either intra-operatively or post operatively as this only risks identifying more low volume positive nodes that may drive unnecessary axillary surgery? This needs to be explored further.

Is axillary clearance becoming an historical operation that we can abandon or are there higher risk groups, the clinical or imaging detected for example, that may still benefit? However with modern radiology it may not be long before the likelihood of detecting a positive node by imaging and biopsy is little different from using blue dye/isotope. If this becomes the case we need to ensure our management of the node positive axilla is consistent regardless of the mode of detection otherwise once again, technology advances drive potentially unnecessary primary clearances for less gain.

The Association of Breast Surgery (ABS) held a consensus MDT meeting in January 2015 to establish UK guidelines for the management of the node positive axilla. The guidelines can be found on the website shortly but in summary: further axillary assessment or post-neoadjuvant SLNB) are likely to be high risk, so clearance seems sensible and reasonable. But what about women with node positive disease on initial axillary assessment or up front SLNB? The standard recommendation of clearance at the end of neoadjuvant therapy is reasonable but doesn’t take into account any disease response to systemic therapy (up to 40% of node positive axillae will convert to node negative).

Consequently the timing of SLNB - before or after systemic therapy - for the clinically node negative axilla is hotly debated with good arguments on both sides. What is known is that SLNB after primary systemic therapy is feasible with comparable false negative rates (10%) using dual technique blue dye/isotope and if three nodes are removed. What is not known is if this approach is oncologically safe.

Definitive evidence of oncological safety is required for a mainstream shift towards axillary conservation after neoadjuvant therapy. In the meantime we must try to maintain a balance between axillary morbidity and oncological safety. It’s worth remembering that over the last two to three decades, despite less radical surgery, breast cancer mortality and local recurrence rates have been steadily declining with better use of tailored targeted treatments.
Nearly 8,000 delegates attended the annual SABCS from 9 to 13 December 2014. Emma Pennery and Grete Brauten-Smith reflect on four presentations from the conference that could impact on UK practice.

**Cuzick J, Sestak I, Cawthorn S et al.**

16 year long-term follow-up of the IBIS-I breast cancer prevention trial. Abstract S3-07

The IBIS-I study was designed to investigate the long-term risks and benefits of taking tamoxifen to prevent breast cancer in women at high risk for developing the disease. Their increased risk of breast cancer was primarily due to a family history of the disease, but some had benign disease associated with increased breast cancer risk.

Updated longer-term follow-up results were presented at SABCS. Of the 7154 pre- and post-menopausal women recruited, half were randomly assigned to receive daily 20-mg tamoxifen for five years, and half a placebo for five years. Women were aged 35 to 70 years, with a mean age of 51; just over 50% were post-menopausal.

After a median of 16 years follow-up, 251 women (8%) from the tamoxifen group and 350 (12%) from the placebo group developed breast cancers, a highly significant difference. The rates of ER+ invasive breast cancer were reduced by 35%. Interestingly in the earlier (10 year follow-up) analysis, tamoxifen reduced the number of ER+ invasive breast cancer and DCIS, but at 16 years the reduction of DCIS didn’t last. No decrease in ER- breast cancers was seen and notably an increase was found in the tamoxifen arm, but this didn’t reach statistical significance.

In women taking tamoxifen, deaths from breast cancer were more frequently seen (31 versus 26 women) but this was not statistically significant. There was also a non-significant, increase in all-cause mortality (182 women (5.1%) died on the tamoxifen arm and 166 women (4.6%) died on the placebo arm of the study).

And women taking tamoxifen had no non-significant increases in endometrial cancer (29 versus 20) and non-melanoma skin cancer (116 versus 84) but decreases in colorectal cancer. Five deaths were seen from endometrial cancer, all in the tamoxifen arm.

**Key points**

- After 16 years, women at high risk who take tamoxifen for five years continue to have a significantly decreased risk of breast cancer.
- 29 women would need to be treated with tamoxifen to prevent one case of invasive breast cancer within 20 years.
- Use of tamoxifen for reducing risk continues to be underwhelming (despite updated NICE familial breast cancer, uptake remains low).
- Patients need careful explanations of risks (other cancers and side effects).
- For post-menopausal women, aromatase inhibitors may soon prove better alternatives, both for effectiveness and side effects.

Francis P et al.

Randomised comparison of adjuvant tamoxifen (T) plus ovarian function suppression (OFS) versus tamoxifen in pre-menopausal women with hormone receptor-positive (HR+) early breast cancer (BC): analysis of the SOFT trial. Abstract S3-08

The Suppression of Ovarian Function Trial (SOFT) was designed to assess the value of ovarian suppression in pre-menopausal women with early breast cancer.

The results presented at SABCS included 3,047 pre-menopausal women with early oestrogen receptor positive (ER+) breast cancer randomised to five years of tamoxifen (n=1018), or ovarian function suppression (OFS) added to either tamoxifen (n=1015) or exemestane (n=1014).

Women having OFS had the choice of monthly injections of the GnRH agonist triptorelin, oophorectomy or radiation ablation, although OFS was achieved entirely by triptorelin in 81% of the patients.

The treatments were compared in two different groups: women who needed chemotherapy (younger age, higher-risk, larger, axillary lymph node positive breast cancer) (53%, n=1628) and those who didn’t (47%, n=1419).

At a median follow-up of 5.6 years, in women not requiring chemotherapy (average age 46 years), tamoxifen alone was sufficient to reduce risk of recurrence. In this group, five-year disease-free survival was 96% with tamoxifen alone, 95% with tamoxifen plus OFS, and 97% with exemestane plus OFS.

However, in women who had chemotherapy and remained pre-menopausal (average age 40 years), tamoxifen plus OFS reduced the relative risk of breast cancer recurrence by 22% compared to tamoxifen alone. Further analysis revealed even greater benefits with exemestane plus OFS, which reduced relative risk of breast cancer recurrence by 35% compared to tamoxifen alone. The five-year disease-free survival rate was 78% for tamoxifen alone, 82.5% for tamoxifen plus OFS, and 86% for exemestane plus OFS.

In absolute terms this means seven or eight fewer women out of 100 having a breast cancer recurrence within five years. The very young women under 35 years (n=350) had lower five year disease-free survival overall, but achieved greater gains from the addition of OFS (68%, 79% and 83% for tamoxifen, tamoxifen plus OFS and exemestane plus OFS respectively).

**Implications for practice**

Oncologists are now increasingly likely to discuss the option of OFS in addition to an aromatase inhibitor or tamoxifen with younger, pre-menopausal women with ER+ breast cancer at high enough risk to be treated with chemotherapy. The results also reiterate the safety and efficacy of tamoxifen alone in older pre-menopausal women with smaller, lower risk breast cancer. In this group there’s no advantage in adding OFS, not least because with an average age of 46, these women will be close to becoming post-menopausal.

Discussions with patients need to include consideration of quality of life. The side effects of OFS are not insignificant. Grade 3 or higher adverse events were reported in 31% of the patients receiving tamoxifen plus OFS, compared to 24% receiving tamoxifen alone.

Hot flushes, sweating, decreased libido, vaginal dryness, insomnia, depression, musculoskeletal symptoms, osteoporosis, hypertension, and glucose intolerance (diabetes) were also more likely in the tamoxifen plus OFS group than in the tamoxifen alone group. Additionally, women receiving exemestane plus OFS had side effects related to sexual functioning. Despite these side effects, hormone therapy wasn’t discontinued any more frequently with the addition of OFS, but rates of non-adherence with ovarian suppression did increase over time (9%, 15%, 18%, and 22% at one, two, three, and four years after randomisation, respectively).

**Key points overleaf**
This study included 2,400 women aged 48-79 who were part of the Women’s Intervention Nutrition Study (WINS), first launched in 1987. Some of the women (n=975) were randomly assigned within six months of diagnosis to follow low-fat diets. These women were given nutrition counselling by dieticians and asked to keep track of their fat intake.

The women in the low-fat group reduced their fat intake by almost 10% of total calories. They also lost an average of six pounds, maintained for five years. After twenty years follow-up, there was no significant difference overall in death rates between the women eating a low fat diet (133 deaths) and the control group (250 deaths). But when researchers separated out the women based on hormone receptor status, they found the low-fat diet seemed particularly helpful for early stage breast cancer patients with ER-negative disease. These women had a median survival of 13.6 years versus 11.7 years in the control group, representing 36% fewer deaths from any cause if they ate a low-fat diet for five years following their diagnosis.

Women who had both ER- and PR- cancers had an even greater reduction in death risk during the study.

Key points
• For women at sufficient risk of recurrence to require adjuvant chemotherapy and who remained pre-menopausal, adding OFS to adjuvant tamoxifen improved disease outcomes.
• Women had an even lower risk of recurrence if they received exemestane plus OFS.
• In women who did not need chemotherapy, five years of aromatase inhibitors was sufficient to reduce recurrence risk; OFS is not of benefit in this group.

Chlebowski R, Blackburn G. Final survival analysis from the randomised Women’s Intervention Nutrition Study (WINS) evaluating dietary intervention as adjuvant breast cancer therapy. Abstract S5-06


Findings from a phase II trial called FIRST (Fulvestrant fIRst-line Study comparing endocrine treatments) were presented at SABCS. This trial compared fulvestrant (delivered by intra-muscular injection on days 0, 14, 28 and every 28 days thereafter) with continuous anastrozole 1mg (taken orally once daily) in post-menopausal women with ER+ metastatic breast cancer patients who had not received any prior endocrine therapy for advanced disease. The study included 205 patients (median age 67 years) from 62 centres across nine countries.

At a median follow-up of 48.8 months, fulvestrant (Faslodex) improved overall survival by nearly six months (54.1 months vs. 48.4 months respectively).

The effect was seen irrespective of patient age, progesterone receptor status, presence of visceral disease or prior adjuvant hormone therapy. Serious adverse effects were similar between fulvestrant (23.8%) and anastrozole (21.4%). The most common adverse effects in the fulvestrant group were bone pain (14%), nausea (11%), arthralgia (10%), constipation (10%), vomiting (9%), and dyspnoea (6%).

Phase III data (for example the FALCON study) is awaited, but these results could contribute to changing practice in first line endocrine therapy for metastatic breast cancer.

Key points
• A low-fat diet and a 6lb weight loss significantly improve survival in women with hormone receptor negative and in women with triple negative early breast cancer.
• The research did not establish the mechanism of action behind the findings.
• Based on findings from other studies on low-fat diets and/or weight loss and breast cancer recurrence risk, losing weight is probably more important than reducing fat.
• Interventions aimed at promoting weight loss and healthier diets report varying success rates and women understandably struggle with sustained motivation and feeling guilty if unable to lose weight.
• With reduced duration of follow-up, it’s uncertain which healthcare professionals should be responsible for this aspect of health promotion.
Conference report: Breast Cancer Care one-day conference ‘Family Ties’

Last November our one-day conference, Family Ties, explored the medical and psychosocial impact a diagnosis of breast cancer can have on the whole family. Catherine Priestley, Secondary Breast Care Nurse at Breast Cancer Care shares her conference highlights.

Vickie Yates, founder of the Younger Breast Cancer Network (UK), spoke about her experience of being diagnosed with breast cancer aged 36 in an inspirational opening address. She highlighted the impact of a diagnosis on every aspect of her life as a younger woman and that of her family; but especially the feeling of isolation despite being surrounded by loved ones who were desperate to help.

Needing to find ‘Someone like me’ Vickie turned to Breast Cancer Care’s discussion forums to find others of a similar age. Attending Breast Cancer Care’s Younger Women Together event in Manchester was a turning point she explained, normalising her feelings within a group where she felt she ‘fitted in’. Discovering that while she had been receiving chemotherapy there were other younger women with similar diagnoses who could have found peer support from each other, Vickie set up a local Facebook group for younger women with breast cancer. This has become a very popular UK-wide closed group with community guidelines, moderated discussion and specialist hubs for those living with secondary breast cancer, pregnancy, regional groups and those facing end-of-life care.

Dr Helen Hanson, Consultant in Cancer Genetics and Jennifer Wiggins, Genetic Counsellor from the Royal Marsden, gave us updates on breast cancer genetics and sharing genetic information with the family. While emphasising that all family members need to know about positive gene testing, we were assured as healthcare professionals that the tricky task of sharing information in some families is necessary to rightly give other family members the opportunity to make an informed decision about genetic testing and how they manage their future risk of developing breast cancer themselves.

The family ties theme continued when Emma Penney, Breast Cancer Care’s Clinical Director, spoke on a familiar situation to many of us in clinical practice. She presented interesting evidence on the relationship between mother and daughter when one or both are diagnosed with breast cancer. We then moved on to intimacy between partners.

Mary Burgess, Consultant Clinical Psychologist at UCLH, discussed the impact of a diagnosis and treatment for breast cancer on intimacy and relationships and explored the benefits of looking at issues from a relationship perspective and the need to translate this into practice.

Dr Helen McKinnon from the charity, See Saw presented on ways in which we can support families with children and young people when talking about secondary breast cancer. Encouraging sensitive and empathetic communication with children about a parents’ illness, Helen stressed the importance of this so that children feel included rather than disconnected from the situation. Talking through a number of ways to do this, Helen signposted to evidence and helpful tools she finds effective in practice.

A continued issue for women yet to start or complete their family was discussed by Consultant Gynaecologist at the Hammersmith Mr Stuart Lavery in a session examining Reproductive Options for women with breast cancer.

Describing fertility issues before and after treatment and the complex women continue to face. He reinforced that all women of reproductive age should have a fertility consultation before treatment to ensure informed decisions are made and timely opportunities taken.

Finally, Dr Alison Jones from the Royal Free and UCLH spoke on treating pregnancy associated breast cancer and consideration of fertility preservation from an oncologists perspective. Discussing the effects of the pregnancy on the cancer and its treatment, effects of treatment on fertility and on current and future pregnancies, we were given an overall view of pregnancy-associated breast cancer and the needs of those affected.

Concluding, Alison told us that standard treatment protocols should be used for women diagnosed during pregnancy modifying and planning treatment according to gestational age. She reinforced the need for clear referral pathways in conjunction with the oncologist to enable women to make clear decisions about their fertility.

Do you know you can download and listen to all the Family Ties presentations?

Go to www.breastcancercare.org.uk/presentations and log in using your email address and Nursing Network membership number, which are included in your cover letter.
Learning together

Professional development opportunities for you and your team

We’ve got a jam-packed professional development calendar to support you and your team in 2015.

We understand the positive impact continuing professional development can have on patient care. We look forward to supporting you and your teams make sure that people facing breast cancer receive the highest quality of care.

Nursing Network Awards

Open to all Nursing Network members our Nursing Network Awards champion best practice in specialist breast care nursing and recognise individuals or teams who have demonstrated innovative and successful nurse-led initiatives. This year, there are three awards up for grabs - patient support or involvement, team initiative and research or audit project.

Winners will be announced at the annual conference and receive up to £1,000. Good luck to all our members – we look forward to receiving your entries.

Dates for your diary
• Entries open 10 April 2015
• Closing date for entries 26 June 2015
• Winners announced 6 November 2015

Download a pack at www.breastcancercare.org.uk/nursingnetworkawards

Specialist nursing forums

Help us improve the standard of care across the UK by joining one of our specialist nursing forums: Younger women’s champions or the Secondary Breast Cancer Nursing Forum. Each forum meets twice a year to share best practice, learn together through clinical updates and drive change in the clinical setting by identifying areas for change.

These national forums give us a great opportunity to work together to make sure these specific patient groups receive the highest possible standard of care.

Join at www.breastcancercare.org.uk/nursingnetworkawards

Annual conference

Our popular annual conference is back on Friday 6 November in central London. We’ll be covering a variety of clinical, practical and psychosocial topics that are central to your role as breast care nurse specialists.

Remember all Nursing Network members qualify for a reduced rate of £45.

You can download all our teleconferences at www.breastcancercare.org.uk/nursingresources.

Log in using your email address and Nursing Network membership number.

Get in touch

We’re happy to help any time, so if you have any questions can speak to the Nursing Network training team on 0845 092 0802 or at nursetraining@breastcancercare.org.uk

Plan your year with the handy pull-out professional development calendar found in this pack.

Teleconferences

Taking place at lunchtime, these free sessions have been designed to fit around your clinical commitments. All you need to join is access to a telephone a computer to see the slides.

Principles of treating secondary breast cancer
Thursday 30 April 2015
Dr Emma Pennery, Clinical Director, Breast Cancer Care
• Aims of treatment for secondary breast cancer
• Guiding principles – determinants of treatment recommendations
• Practice implications (access, supportive care)

Ovarian suppression and ablation
Monday 22 June 2015
Dr Marina Parton, Consultant Medical Oncologist, The Royal Marsden Hospital invited
• Different methods of suppression and ablation
• Patient selection
• Update on trial data

Update on lung metastases
Tuesday 26 January 2016
Dr Mark Harries, Consultant Medical Oncologist, Guys & St Thomas’ Hospitals NHS Foundation Trust
• Incidence and outcomes
• Diagnosis and re-biopsy?
• Treatments

You can download all our teleconferences at www.breastcancercare.org.uk/nursingresources.

Genomics and breast cancer
Wednesday 23 September 2015
Isobel Greenfield, Director of Medical Affairs UK, Genomic Health Inc invited
• Making decisions about adjuvant treatment
• Prognostic tools and genomic tests
• Oncotype DX®

Online members’ area

A wealth of information is available to members at www.breastcancercare.org.uk/nursingresources. You can:
• access resources and nursing toolkits
• join our specialist nursing forums – Younger Women’s Champions and Secondary Breast Care Nurses Forum.

We’ve made it easier to log in by resetting your username and password to your email address and Nursing Network membership number. You’ll find these details on the letter you received with this issue of Nursing Network News.
Genetics for Health Professionals in Cancer Care – From Principles to Practice

Edited by Chris Jacobs, Patricia Webb and Lorraine Robinson


Lee Burgess, Helpline Nurse at Breast Cancer Care and retired Breast Screening Clinical Nurse Specialist reviews the new cancer genetics text book.

This book is aimed at health professionals who have contact with people concerned about their family history of cancer, or who care for patients with hereditary cancer.

The book contains contributions from a wide range of specialists. The summary provided by the editors provides suggestions for further reading and guided activities to aid health professionals in developing their skills in their own area of practice.

The early chapters on basic genetics and cancer biology provide an informative introduction. Those which focus specifically on the genetics of breast and ovarian cancer will be of interest to nurses working in the breast cancer specialty.

The breast-specific information is up to date in accordance with the latest NICE guidance regarding familial breast cancer published in 2013.

Highlights for nurses managing breast cancer family history clinics include the latest information on risk assessment and categorisation of people with a family history of breast and ovarian cancer, current screening recommendations for women with personal or family history of breast cancer; and options for reducing the risk of breast cancer including chemoprevention and risk-reducing surgery.

The benefits and challenges of setting up and managing cancer family history are explored. There is a practical guide to setting up a family history clinic and examples of current working models.

Sections 7 - 8 examine the challenges of managing people with hereditary breast cancer and their particular support needs, provide an insight into the process of genetic counselling and a greater understanding of the associated psychosocial, cultural and ethical issues for an individual and their family.

Recent advances in genome sequencing and high-profile media reports regarding hereditary breast cancer have raised awareness of these issues for the general public. The targeting of cancer treatments through genetic profiling is becoming a reality, and will be increasingly incorporated in the management of people with cancer. This book will enhance the knowledge and skills currently held by nurses, therefore improving confidence when having conversations with patients about their family history; and enable them to identify and support those affected by hereditary breast cancer more effectively.

It will be an invaluable resource for any nurse with an interest in cancer genetics or specialising in breast care, and I would recommend that every breast unit should have a copy.

Resources update - benign breast conditions

Jackie Harris, Clinical Nurse Specialist at Breast Cancer Care highlights our popular series of patient information about benign breast conditions.

You might think that the most requested Breast Cancer Care publications are those on breast cancer and its treatments. In fact, our most requested publication last year was from our benign breast conditions series. We sent out 70,000 printed copies of our Breast pain booklet.

As we discussed in an earlier issue of Nursing Network News, most breast clinical referrals are normal/benign diagnoses, so in 2012, we focused on developing a series of booklets on benign breast conditions. Over the years, the number of requests for the 13 booklets in this series has increased significantly. Popular printed copies include: breast cysts, fibroadenoma, gynaecomastia and breast calcifications.

The number of visitors to our website continues to grow and analysis has shown benign breast conditions features highly in the top 25 perused pages.
Services for patients

Designing a new culturally accessible supportive self-management intervention for breast cancer survivors from a patients’ perspective

Introduction
It’s widely recognised that the time after completing hospital-based treatment is particularly challenging for breast cancer patients. However, little is known about whether the supportive care needs of breast cancer patients from different groups and backgrounds were the same or different, and then adapt or develop a new intervention that would help to improve the quality of life and wellbeing of breast cancer patients from diverse ethnic and socio-economic groups.

In 2011 Breast Cancer Care began a two-phased research study in England that firstly aimed to identify whether the supportive care needs of breast cancer patients from different groups and backgrounds were the same or different, and then adapt or develop a new intervention that would help to improve the quality of life and wellbeing of breast cancer patients from diverse ethnic and socio-economic groups.

Phase 1: Top-line results: interviews with patients
66 women, within their first 12 months of completing hospital-based treatment, were recruited from across eight NHS trusts in the UK to take part in a face-to-face interview. Participants ages ranged from 34 to 84 years old (mean average age of 54 years). 23 participants were White British, 21 were Black Caribbean/Black African, 17 were South Asian, 5 were of mixed ethnicity or ‘Other’ ethnic groups. Of the 43 Black and minority ethnic (BME) women, were of mixed ethnicity or ‘Other’ ethnic groups. The Caribbean/Black African, 17 were South Asian, 5 were of mixed ethnicity or ‘Other’ ethnic groups. Of the 43 Black and minority ethnic (BME) women. The study included 66 women, 22 black patients and 21 staff together) and one in December 2013 (one with 18 hospital and community staff working with black women, one with 20 black breast cancer patients and one with 22 black patients and 21 staff together) and one in March 2014 (with 32 South Asian cancer patients).

What we did
We held three facilitated workshop events in March 2014 (with 32 South Asian cancer patients). They were the same or different, and then adapt or develop a new intervention that would help to improve the quality of life and wellbeing of breast cancer patients from diverse ethnic and socio-economic groups.

Breast Cancer Care has been busy developing a new supportive self-management programme, with volunteers, clinicians and experts in the field of self-management. This will be piloted between March-December 2015 as part of a feasibility study. Participants on the PROWESS programme are being recruited from three NHS hospital trusts and from local community advertisements. The service is open to anyone who has finished their hospital treatment for breast cancer in the last 12 months (from date they were recruited to participate in the PROWESS study).

The programme will be co-facilitated by an experienced facilitator with a therapeutic background and a specially trained PROWESS volunteer, who has had breast cancer. Some sessions will be led by expert speakers.

For more information email karen.scanlon@breastcancercare.org.uk

www.breastcancercare.org.uk
‘Five years on, and I still feel the fear’
#hiddeneffects

Breast cancer’s never really over. Help us be there for as long as it takes.

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