BREAST CANCER REFERRAL GUIDELINES- GG & C
Based on Scottish Referral Guidelines

Breast symptoms are a relatively uncommon presentation in primary care. It is estimated that between 0.35% and 0.6% of all consultations in Scotland are for breast symptoms. Many of these consultations will be in young women, whereas the biggest risk factor, after gender, is increasing age. Incidence of breast cancer in women aged 30-35 is 33 per 100,000 population and approximately 81% of breast cancers occur in women over the age of 50.

Breast cancer accounts for 30% of cancers in women and around 4,400 people are diagnosed with breast cancer in Scotland each year; approximately 20 of these are men. The following recommendations seek to improve the referral and effective management of breast symptoms in women and men in primary care. Guidance for referral to regional genetics centres for those with a family history of breast cancer is available at:

http://www.healthcareimprovementscotland.org/our_work/cancer_care_improvment/programme_resources/familial_breast_cancer_report.aspx

	Urgent suspicion of cancer referral	Routine referral	Primary care management Issue relevant advice leaflet
Under 35 years old		♦ Any new discrete lump in patients under 35 years with no other suspicious features ♦ New asymmetrical nodularity that persists at review after menstruation (in patients under 35 years)	♦ Women with longstanding tender lumpy breast and no focal lesion ♦ Tender developing breasts in adolescents
Pain		♦ Unilateral persistent pain in post menopausal women ♦ Intractable pain the interferes with the patient's lifestyle or sleep	♦ Women with moderate degrees of breast pain and no discrete palpable lesion
Lump	♦ Any new discrete lump (in patients over 35 years) ♦ New asymmetrical nodularity that persists at review after menstruation (in patients over 35 years) ♦ Unilateral isolated axillary lymph node in women ♦ Cyst persistently refilling or recurrent cyst	♦ Any new discrete lump in patients under 35 years with no other suspicious features ♦ New asymmetrical nodularity that persists at review after menstruation (in patients under 35 years)	♦ Women with longstanding tender lumpy breast and no focal lesion ♦ Tender developing breasts in adolescents
Nipple symptoms	♦ Bloodstained discharge ♦ New nipple retraction ♦ Nipple eczema if unresponsive to topical steroids (such as 1% hydrocortisone) after a minimum of 2 weeks	♦ Persistent discharge sufficient to stain outer clothes	♦ Transient nipple discharge which is not bloodstained ♦ Check prolactin levels when discharge present ♦ Longstanding nipple retraction ♦ Nipple eczema if eczema present elsewhere

Skin changes	♦ Skin tethering ♦ Fixation ♦ Ulceration ♦ Peau d'orange		♦ Obvious simple skin lesions such as sebaceous cysts
Abscess / infection	♦ Mastitis or breast inflammation which does not settle after one course of antibiotics	♦ Abscess or breast inflammation even after settled in patients over 35 years	♦ Abscess* or inflammation – try one course of antibiotics to cover staphylococcus and streptococcus (also consider possible anaerobic infection as per local guidelines)
Gynaecomastia		♦ Exceptional aesthetics referral to plastic surgery pathway if required ♦ Exclude or treat any endocrine cause prior to referral	♦ Examine and exclude abnormalities such as lymphadenopathy or evidence of endocrine condition ♦ Review to exclude drug causes ♦ Measure hormones (oestrogen, testosterone, prolactin, human chorionic gonadotropin and alpha-fetoprotein) ♦ Reassure

* Any acute abscess requires immediate discussion with secondary care.

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