Transformation Partners in Health and Care

RM Partners West London Cancer Alliance
Hosted by The Royal Marsden NHS Foundation Trust

NHS

Original leaflet developed by RM Partners

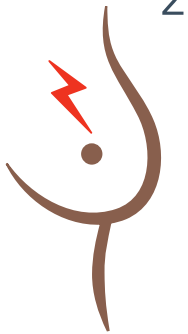
1. Breast lump

If patient presents with a solitary, distinct lump refer on 2ww

Other red flag symptoms for urgent referral include:

- **Blood stained, or watery single duct nipple discharge. Most common cause is a intraduct papilloma but a cancer needs to be excluded**
- **Skin puckering/tethering**
- **Unilateral new nipple inversion**
- **Unexplained axillary lump**

2. Breast pain



Do not refer:

Breast pain as a sole presenting symptom does not require referral. There is no association between breast pain and breast cancer, when no breast lump identified, according to the British Journal of General Practice. **doi.org/10.3399/BJGP.2021.0475**

- Most women will present with breast pain at some stage in life. It is NORMAL. It does NOT require referral, investigation or in most instances treatment, unless a breast lump is also identified.

➜ see page 3 more information

3. Breast nodularity

Breasts are naturally nodular especially in upper outer quadrants

Do not refer:

- Breast nodularity/lumps that come and go
- Nodularity that is symmetrical
- Nodularity is associated with tenderness
- Nodularity that patient has difficultly defining / demonstrating to you

If any of the above reassess soon after their next period

Only refer if:

- **At reassessment asymmetric persistent nodularity**

4. Nipple discharge

Many women experience a physiological nipple discharge. The discharge is usually yellow, milky, or green, and it can often be seen to be coming from more than one duct.

Do not refer:

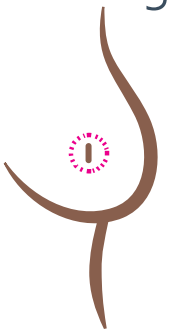
- Bilateral discharge
- Multiduct discharge
- Bilateral or multiduct discharge that only occurs with pressure
- Discharge on areola caused by excoriation and eczema

Do refer

- **Single duct unilateral blood-stained or watery discharge**

➜ see page 4 more information

5. Nipple changes



Do not refer:

- Bilateral nipple inversion
- Long standing nipple inversion
- Bilateral nipple / areola eczema: if a patient has a history of eczema and the changes are bilateral try a course of topical steroid cream

Do refer if:

- **New unilateral nipple inversion**
- **Unilateral 'eczema'. Paget's disease changes start on the nipple, are eccentric and spread from the nipple to areola**

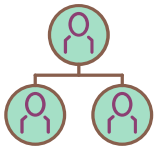
6. Family history of breast cancer

Do not refer:

- Family history of only 1 first degree or 1 second degree relative diagnosed older than 40 years

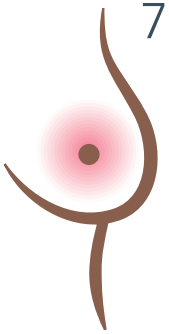
➜ see page 5 more information

Do refer to family history service:



- **First degree relative diagnosed younger than 40**
- **First degree relative diagnosed with bilateral breast cancer younger than 50**
- **2 first degree or 1 first degree and one second degree relative with breast cancer at any age**
- **If known germline mutation in the family refer to the regional genetics service**

7. Breast Sepsis



Do not refer:

- Do not refer infected sebaceous cyst

➜ see page 6 more information

8. Skin lesions

Do not refer:

- Sebaceous cysts that occur on breast – the cyst is in dermis not breast
- Moles
- Skin rashes
- Skin tags

9. Male breast lumps

Please see ABS guidance on management of gynaecomastia **abs-summary-statement-gynaecomastia-v3.pdf associationofbreastsurgery.org.uk**

Do not refer:

- Adolescents and elderly men with gynaecomastia – this is physiological and occurs in up to 60% of pubertal adolescents and elderly men
- Drug related gynaecomastia: take drug history and check BNF if uncertain if gynaecomastia is a side effect
- Bilateral pseudo gynaecomastia ie. fatty breasts

Do refer:

- **Eccentric hard masses**
- **Painful unilateral gynaecomastia**

2. Breast pain

Breast pain as a sole presenting symptom does not require referral to secondary care. There is no association between breast pain and breast cancer, when no breast lump identified, according to the British Journal of General Practice. **doi.org/10.3399/BJGP.2021.0475**

a. **Most women will present with breast pain at some stage in life.** It is NORMAL. It does not require referral, investigation or in most instances treatment.

b. **Strong reassurance is required.** Give link to RMP video **New video to help understand breast pain - RM Partners**. Give link to breast cancer now breast pain leaflet **Breast pain: Causes, types and treatments | Breast Cancer Now** Give link to CoppaFeel web page on breast pain Breast Pain - **coppafeel.org.uk/info-resources/health-information/breast-pain/**

c. **Stress is a trigger, enquire re stress.** Possible stress concern due to FHx. See section 9 on family history.

d. **Treatment is not usually required, pain will settle spontaneously with time, may be recurrent and episodic.** Ensure they have proper fitting bra, avoiding wired bra may help. Routine analgesia can be advised if pain interfering with QoL: paracetamol, topical NSAID. If cyclical could consider OTC preps such as evening primrose GLA 200mg-300mg a day. GLA probably no better than placebo but works for some.

e. **If of NHS Breast Screening programme age 50-70 years,** enquire when last mammogram was performed and assuming it was normal this should be used to provide added reassurance.

f. **Note if patient is referred many units are now triaging and patient may not be seen F2F.** If under 40 or has had a normal mammogram in last 12 months they may not have any investigations if referred.

4. Nipple discharge

Nipple discharge is very common. Fluid can be obtained from the nipples of approximately 50-70% of normal women. This discharge of fluid from a normal breast is referred to as physiological discharge. This discharge is usually yellow, milky, or green in appearance, it does not happen spontaneously, and it can often be seen to be coming from more than one duct. Physiological nipple discharge is not a cause for concern.

a. Do not refer

- Bilateral discharge: the patient may not be aware it is bilateral so check by applying firm pressure
- Multiduct discharge: check by applying pressure if coming from more than one duct
- Bilateral or multiduct discharge that only occurs with pressure
- Discharge on areola caused by excoriation and eczema see section 5.

b. The differential for symptoms listed in section a) include:

- Galactorrhoea – check prolactin and if raised check for causes or refer to an endocrinologist
- Physiological nipple discharge
- Duct ectasia: a benign condition in which the ducts under the nipple enlarge and there is inflammation in the walls of the ducts. It usually occurs in women after menopause. The discharge caused by duct ectasia usually comes from both breasts (bilateral), is yellow, green or brown, and comes from more than one duct. In most cases, no treatment is needed. If the discharge is a nuisance, the ducts behind the nipple can be removed surgically.

c. Do refer:

- **Single duct unilateral blood-stained or watery discharge.**

6. Family history of breast cancer

Recommendations | Familial breast cancer: classification, care and managing breast cancer and related risks in people with a family history of breast cancer | Guidance | NICE see section 1.3. Need to take history from both sides of the family including age. Recommend use of QUEST Genomics app - **www.ubqo.com/cancergenetics**. Enquire about bilateral breast cancer, male breast cancer, ovarian cancer, sarcoma, glioma and adrenocortical childhood cancers, Ashkenazi ancestry.

a. Do not refer if:

- Family history shows only 1 first degree or 1 second degree relative diagnosed older than 40 years

b. Do refer to family history services if:

- **First degree relative diagnosed younger than 40**
- **First degree relative diagnosed with bilateral breast cancer younger than 50**
- **2 first degree or 1 first degree and one second degree relative with breast cancer at any age**

c. If known germline mutation **in the family refer to the regional genetics service**

7. Breast Sepsis

a. **Lactational infection: try Flucloxacillin in first instance.**

- If penicillin allergy: try Erythromycin (preferred if pregnant) or Clarithromycin 250-500 QDS/500 Bd for 10-14 days.
- Encourage continued breast feeding and regular paracetamol. If does not settle refer to breast clinic for USS and aspiration.

b. **Non-lactational infection often occurs around the nipple: periductal mastitis.**

- Periductal mastitis: usually associated with a tender lump in the nipple region with associated erythema and nipple discharge. More common in smokers and can be a chronic condition.
- Prescribe co-amoxiclav 500/125 tds for 10-14 days.
- If penicillin allergic: Erythromycin or Clarithromycin with Metronidazole. **cks.nice.org.uk/topics/mastitis-breast-abscess/management/management-non-lactating-women/**
- If does not settle after 2 weeks of antibiotics refer to breast clinic.