Breast cancer treatment: doctor's dilemma or patient's choice?

Dr Louise Newson, *Women's Health* Consultant Editor, provides a summary of a recent conference that looked at the challenges facing health professionals when it comes to breast cancer treatment

This conference was held at the Royal Society in London on Wednesday, 31 October 2018, during Breast Cancer Awareness Month. The aims of this day were to address three keys areas where women are often denied information they need, in order to make shared decisions with their doctors regarding their own health needs.

There was a really stimulating and interesting debate regarding the benefits and harms around breast screening. Prof Tony Howell, professor of medical oncology in Manchester, started the debate by providing evidence to support the use of breast screening. Screening has been shown to diagnose smaller tumours, reduce the extent of treatment and reduce deaths from breast cancer.

Prof Mike Baum, professor emeritus of surgery in London, responded by giving facts regarding potential harms of breast screening. Breast scanning can detect ductal carcinoma in situ, which may never progress to breast cancer. The detection of ductal carcinoma in situ has risen since the introduction of breast screening. Breast screening can lead to women being over diagnosed and treated for a lesion that may never lead to harm. For every one woman whose life has been saved by screening, there are approximately three women receiving unnecessary treatment. Additionally, breast screening does not detect all cancers. There are also potential harms of treatment, including increased risk of cardiovascular disease with radiotherapy. Furthermore, death rates in women from any cancer following breast screening are unchanged compared to death rates in women who have not undertaken breast screening.

Both of these experts talked about the need for having more targeted breast screening, which involves risk assessment. Women at low risk of breast cancer should be given more advice regarding lifestyle, and women at a higher risk should be offered genetic testing in addition to breast screening. Around 20% of women are at high risk and around 20% of women are at low risk. The women at high risk of breast cancer seem to be more likely to have a worse stage of breast cancer and a higher grade, and these women would potentially benefit the most from breast screening. Clearly more work needs to be done in this area to assess risk in women before they opt for screening.

> *GPs are often well-placed to discuss implications of breast screening with their patients*

Dr Renee Hoenderkamp, a GP with a special interest in women's health, discussed problems in primary care with respect to breast screening. GPs are not involved in the breast screening process in the same way that they are with cervical screening. This means that many women have breast screening without it being an informed choice. She suggested that this should change as GPs are often well-placed to discuss implications of breast screening with their patients. All women need to be encouraged to undertake regular self-examination.

The next speaker was Avrum Bluming, who is a clinical professor of Oncology in Southern California, USA. He has recently co-authored a book, *Oestrogen Matters: why taking hormones and menopause can improve women's well-being and lengthen their lives –*

> *There are a lack of menopause specialists and this is very concerning as many NHS menopause clinics have been closed in recent months*

without raising the risk of breast cancer. His book has been written to enlighten us with detailed information about oestrogen. There is detail regarding the history of the Women's Health Initiative Study, which was wrongly reported to the media. It also presents, in detail, numerous studies supporting the benefits of taking HRT. He presented evidence to support that taking HRT reduces future risk of osteoporosis, cardiovascular disease and dementia. In addition, women taking HRT have been shown to have a lower mortality from all causes including cancer.

He was very open about the fact that his wife and daughter had a history of breast cancer but they had chosen to take HRT. He discussed evidence that taking HRT does not increase future incidence or recurrence of breast cancer in women who have had breast cancer in the past. One sobering fact was women who are pregnant and clearly have high levels of circulating oestrogen and develop breast cancer during their pregnancy do not have a worse prognosis by continuing with their pregnancy. In addition, women are more likely to develop breast cancer after the menopause when their oestrogen levels are low, so many women develop breast cancer related to oestrogen. Both these facts clearly question the role of oestrogen in the development of breast cancer.

I followed his very inspirational talk by presenting two women who I have seen in my clinic who have both been denied HRT from their GPs in the past. Both women were having significant symptoms that were having a very negative effect on their lives, and one of the women had given up her job because of the effects on her memory and cognition. She had been treated for breast cancer in the past and had tried numerous alternative preparations for her menopausal symptoms. However, she elected to take HRT and her life has now been transformed and her quality of life is now considerably better. She understands there might be an increased risk of developing recurrence of her breast cancer, but she feels this has been offset by the other benefits taking HRT gives her.

Diane Danzebrink then followed, talking about the role of the menopause counsellor and discussed her frustrations in there being inadequate support and advice for menopausal women in the UK. There are a lack of menopause specialists and this is very concerning as many NHS menopause clinics have been closed in recent months.

The afternoon was chaired by Dr Margaret Spittle OBE, and involved a discussion regarding intraoperative radiotherapy. This treatment is not widely offered despite there being excellent evidence to support its use. Marcel Benstein, a patient who had received this treatment, gave a very emotive talk about the importance of having choice regarding her treatment for breast cancer.

The day concluded with a very enlightening talk by Suzanne White, who is head of negligence for Leigh Day. She discussed the legal and ethical responsibilities of doctors regarding shared decision-making. Many healthcare professionals are wrongly concerned about being sued if their patients either refuse potentially beneficial treatment or accept treatment that could possibly be harmful.

As a healthcare professional, I strongly feel my patients should be given informed choices and we should help them with their decision-making – but we should also respect their choices even if we do not totally agree with them!

> *Women are more likely to develop breast cancer after the menopause when their oestrogen levels are low*

BJFM Challenge answers (see pages 8-9)

1.	b	(see pages 10-14)
2.	e	(see pages 10-14)
3.	c	(see pages 10-14)
4.	b	(see pages 22-23)
5.	e	(see pages 22-23)
6.	d	(see pages 22-23)
7.	a, b, c, d	(see pages 22-23)
8.	a	(see pages 28-31)
9.	e	(see pages 28-31)
10.	b, d	(see pages 28-31)
11.	a	(see pages 32-35)
12.	d	(see pages 32-35)
13.	c	(see pages 32-35)
14.	d	(see pages 36-37)
15.	b	(see pages 36-37)