GP Education Pack - NICE Familial Breast Guidelines

Q&As as at 24.10.14

The Q&As will be updated on an ongoing basis. Please submit any questions to Denise Friend at the Strategic Clinical Network at denise.friend@nhs.net

Question		Answer	Date
1	The tamoxifen guidelines state that the decision is not for the GP to make, but then it says it is and to initiate the drug.	The decision for eligibility and decision to prescribe / initiation of prescription is at secondary care level, and at secondary care level every effort will have been taken to identify any contra-indications or drug interactions - and GPs are only providing an extra layer of safety essentially.	**27.3.14**
2	I am in the process on trying to implement the FH guidelines-what I can't remember is if we had agreement in the SCN document regarding mammograms in the moderate risk group NICE says consider mammos from 40-59-currently we do them till 50-was there a consensus that we would implement this: The SCN document says: **1. Mammography** The largest impact of the guideline will be on symptomatic mammography services. The	A compromise of 3 yearly MMG from 50-59 to alternate with the 3 yearly NHS BSP MMG has been agreed.	**1.4.14**

	recommendation is to **consider** annual mammographic surveillance for women aged 50-59 at moderate risk of breast cancer. However, yearly mammography as recommended in the 40-49 year old group (NICE CG41, 2006) has not consistently been adopted across the region. **1.1.** Mammography for moderate risk patients is managed via the symptomatic call and recall service. The cost of mammography remains within outpatient tariff; therefore although the number of mammograms performed will increase there is no associated tariff. The first outpatient tariff currently covers all mammography.		
3	At our area prescribing meeting held last week the prescribing of prophylactic tamoxifen was discussed and agreed that as this drug is an unlicensed product for the use it is being recommended in primary care. The LMC is to contact GPs this week. At the present time it seems unlikely that any general practitioner will be engaging with the familial breast service in terms of the prescribing and family history elements. Can you advise what is happening in other areas - have similar concerns/decisions been taken.	No similar concerns have been raised to date. GPs prescribe lots of drugs in primary care outside licence when recommended by specialists. In this case, the use is NICE approved and being prescribed on the advice of a specialist, and needs no monitoring (supported by written guidance and a named contact in secondary care should any problems arise). This has been through the Joint Area Prescribing Committee in Derbyshire who, taking into account the above, are happy with the prescribing of tamoxifen by GPs in this way, as is Bradford CCG.	**29.4.14**
4	I would have preferred that there was no 'alternating' 18 monthly mammograms in this pathway as it complicates an already complex pathway. I think it would have been better to leave this out or debate it further	The imaging guidance from the SCN applies only to women not covered by the NHSBSP. Very high risk women (e.g. BRCA/TP53 gene mutation carrier, or not tested-equivalent high risk*) can be referred to the NHSBSP between the ages	**12.6.14**

		of 30 (20 for TP53) and 69 for high risk screening. *As defined by a geneticist Therefore, this guidance covers screening in secondary care services for women at moderate or high risk of familial breast cancer not meeting the criteria for the NHSBSP very high risk screening programme. Secondly, The NICE guidance is the Gold standard. If your unit is able to comply with the 2013 NICE guidance then this should be followed instead of the SCN advice. The SCN guidance was produced following a meeting with clinicians from across Yorkshire and Humber. The aim was to ensure equity of access for a service which we knew to be patchy and incomplete in some areas. We hoped it would lead to discussions between commissioners and providers. It is a stepping stone to full compliance with the NICE guidance. We found the word 'consider' to be problematic at the workshop in October; this definition was identified from within the full NICE guidance: 'Consider'– the benefit is less certain, and an intervention will do more good than harm for most patients. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values and preferences than for an 'offer' recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient. The onus therefore is on the clinician to explain as effectively as possible the risk/benefit to women, recognising that some	

		women are better equipped to understand risks and benefits than others, even after extensive counselling. Our recommendations omitted high risk women with <=30% risk of being a BRCA or TP53 carrier. These women should have an annual mammogram from 40-59. The recommendations are similar for moderate risk patients with the word 'consider' used for annual MMG from 50-59. The NHSBSP covers 3 yearly mammograms. The clinically led recommendation for women at moderate risk in the age range 50-59 was to aim for 18 monthly mammograms (alternating BSP and symptomatic) at least. Providers will need to discuss with their CCGs how they meet the minimum requirement recommended by the SCN and how they work to a position of being able to support the NICE guidance in full. The NICE guidance asks us to consider annual mammography from 30-39 for women at high risk but with <=30% probability of being a BRCA carrier. This was not discussed at the workshop. An opinion voiced at the Association of Breast Surgery meeting was that the risks of this outweigh the benefits. For those units able to adopt the NICE guidance in full, the risks and benefits should be discussed with each patient. Apologies for the confusion around this and hope that this goes some way to addressing concerns.	
5	Please provide clarification on the GP pathway / assessment and what if anything providers will receive	GPs should take a full first and second degree relative family history, as well as ethnic origin history and on the basis of this	**30.6.14**

	with the referral so we do not duplicate and ask patients the same questions - (we currently receive paper referrals form GP's) but will be wanting to move to Choose & Book hopefully directly bookable over the coming weeks / months.	history decide whether or not to refer a woman to the clinic and as such include the relevant parts of that history.	
6	Is it compulsory to use the SystmOne template?	It's not compulsory to use the SystemOne template itself, but the pathway is regionally agreed so does need to be followed. If it's not followed and patients are referred inappropriately to breast clinic and/or Genetics, they may be bounced.	**23.10.14**