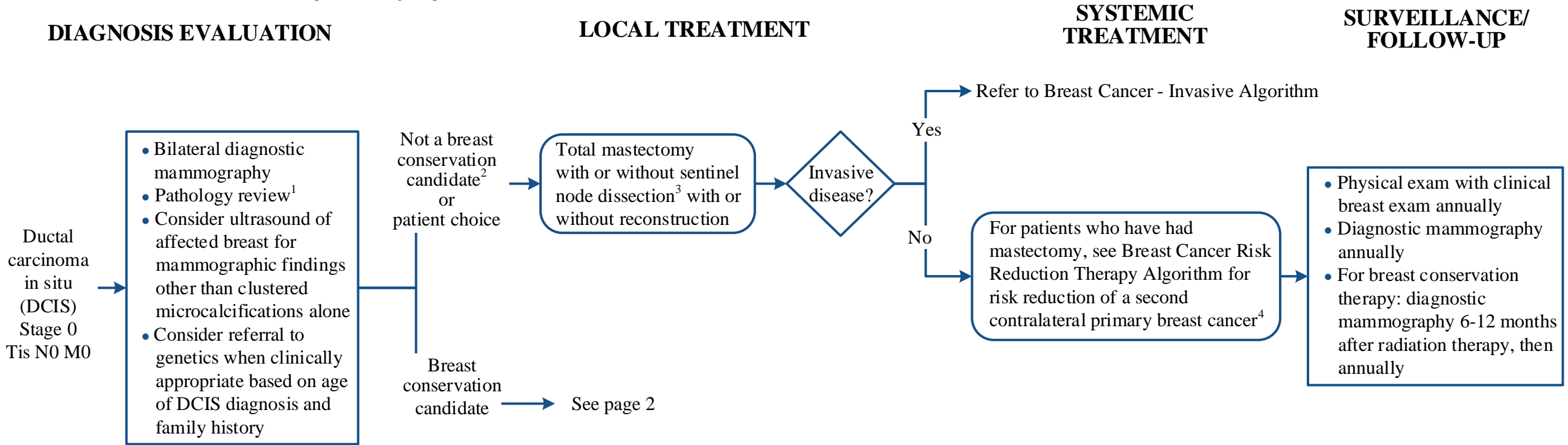


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Note: Consider Clinical Trials as treatment options for eligible patients.



¹ Pathology review to include:

- Tumor size
- Rule out invasive component
- Lymph node status if lymph node surgery performed
- ER/PR status, preferably on the surgical specimen (unless patient is undergoing bilateral mastectomy)
- Margin status
- Nuclear grade
- Histologic type/necrosis

² Candidates for breast conservation therapy:

- Unicentric disease
- Tumor to breast size ratio allows for acceptable cosmetic result
- Attempt margins greater than or equal to 2 mm
- No evidence of diffuse microcalcifications on mammography
- No contraindication to radiation therapy

³ DCIS lymph node evaluation not recommended unless patient having total mastectomy which would preclude mapping at a later date if invasive disease noted on final pathology.

⁴ For estrogen receptor (ER) or progesterone receptor (PR) positive DCIS, Endocrine therapy with tamoxifen for 5 years or aromatase inhibitor (AI) therapy is also an option for postmenopausal patients for risk reduction. See Breast Cancer Risk Reduction Therapy Algorithm for risk reduction of a second contralateral primary breast cancer. For patients who underwent bilateral mastectomy, there is 0 indication for risk reduction therapy.

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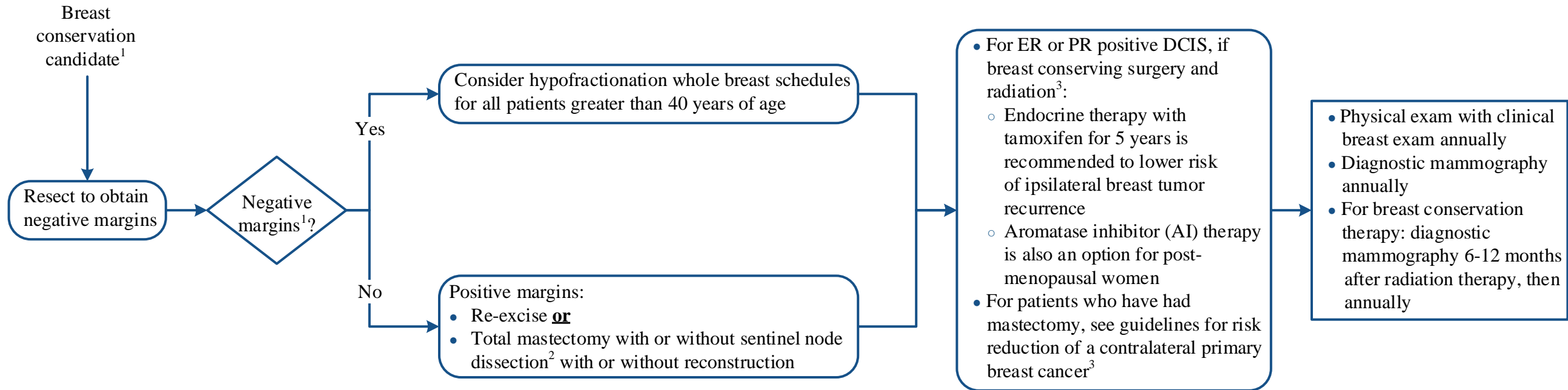
Note: Consider Clinical Trials as treatment options for eligible patients.

DIAGNOSIS EVALUATION

LOCAL TREATMENT

SYSTEMIC TREATMENT

SURVEILLANCE/ FOLLOW-UP



¹ Candidates for breast conservation therapy:

- Unicentric disease
- Tumor to breast size ratio allows for acceptable cosmetic result
- If less than 2 mm negative margins and planned radiation therapy, multidisciplinary planning to consider need to re-excite and consider radiation therapy boost 14-16 Gy as an alternative to re-excision
- If less than 2 mm and no planned radiation therapy, re-excite

² DCIS lymph node evaluation not recommended unless patient having total mastectomy which would preclude mapping at a later date if invasive disease noted on final pathology.

³ For ER or PR positive DCIS, if patient undergoes breast conserving surgery and radiation, endocrine therapy is recommended to lower risk of ipsilateral breast tumor recurrence. The magnitude of local recurrence risk reduction depends on absolute risk of local recurrence based on factors such as grade and size (molecular profiling impact still is uncertain). Tamoxifen 20 mg daily for 5 years is approved to lower ipsilateral breast tumor recurrence after breast conserving surgery and radiation. AI therapy (anastrozole 1 mg daily for 5 years) has been shown to be equally effective, yet not FDA-approved for this indication. Endocrine therapy can also be considered for ER or PR positive DCIS treated with breast conserving surgery without radiation, but less supportive data exists. For patients undergoing mastectomy, refer to breast cancer prevention guidelines for prevention of a contralateral breast cancer.

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