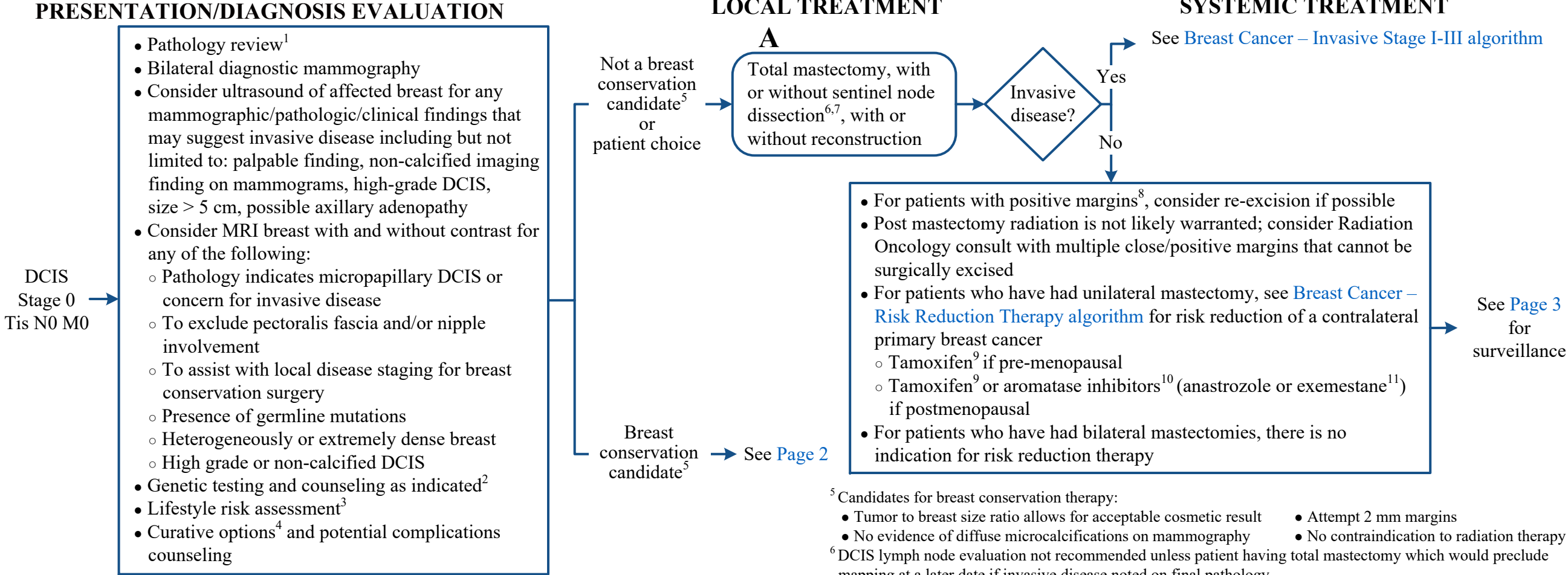


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Note: Consider Clinical Trials as treatment options for eligible patients.



¹ Pathology review to include: • Tumor size • Rule out invasive component • Margin status
• Nuclear grade • Lymph node status if lymph node surgery performed • Histologic type/necrosis
• Estrogen receptor (ER)/progesterone receptor (PR) status, preferably on the surgical specimen (unless patient is undergoing bilateral mastectomy)

² See [Genetic Counseling algorithm](#)

³ See [Physical Activity](#), [Nutrition](#), [Obesity Screening and Management](#), and [Tobacco Cessation Treatment](#) algorithms

⁴ Recently published randomized control trial found that women with grade 1 or 2 DCIS randomized to active monitoring with mammograms every 6 months did not have a higher rate of invasive cancer at 2 years compared with those randomized to surgical intervention. Longer follow-up will determine whether active monitoring offers durable safety and acceptability for patients.

⁵ Candidates for breast conservation therapy:

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

⁶ 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

⁷ Contralateral risk-reducing mastectomy may be considered in patients with a high-risk for future breast malignancy (e.g., mutation carrier including *BRCA*, *PALB2*, and/or *CHEK2*, strong family history of breast cancer, history of chest wall radiation)

⁸ For patients undergoing mastectomy, no tumor on ink is an acceptable margin

⁹ Tamoxifen is the primary choice for premenopausal patients, unless concerns for thromboembolism or history of uterine cancer/atypical hyperplasia. Starting dose of tamoxifen is 20 mg by mouth once daily; may reduce to 5 mg once daily if needed for patient tolerance.

¹⁰ Off-label (Not FDA approved) but evidence-based

¹¹ If patient is intolerant of tamoxifen, anastrozole, and exemestane, the use of letrozole may be considered

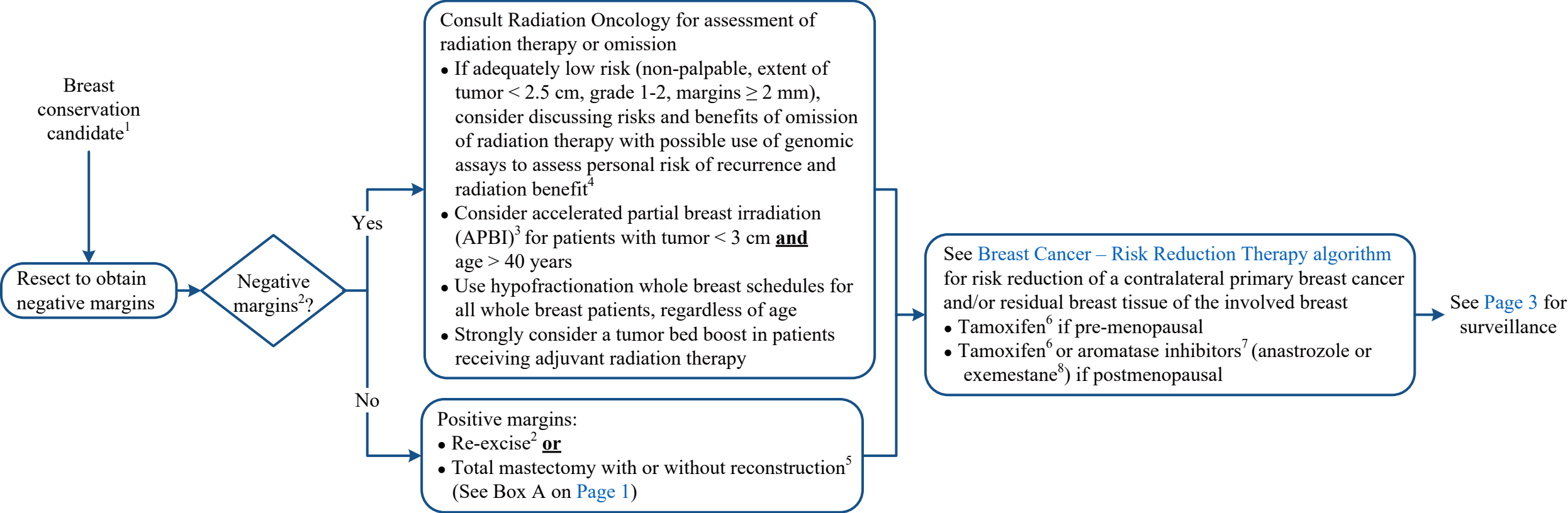
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Note: Consider Clinical Trials as treatment options for eligible patients.

DIAGNOSIS EVALUATION

LOCAL TREATMENT

SYSTEMIC TREATMENT



¹ Candidates for breast conservation therapy:

- Tumor to breast size ratio allows for acceptable cosmetic result
- No evidence of diffuse microcalcifications on mammography
- Attempt 2 mm margin
- No contraindication to radiation therapy

² Negative net margins:

- If < 2 mm negative margins and planned radiation therapy, multidisciplinary planning to consider need to re-excise and consider radiation therapy boost 14-16 Gy as an alternative to re-excision
- If < 2 mm negative margins and no planned radiation therapy, re-excise

³ 38.5 Gy twice daily in 10 fractions or 30 Gy in 5 fractions given every other day are regimens supported by phase III data for DCIS

⁴ Limited prospective data exist for these assays, and enrollment on clinical trials to evaluate their utility in a prospective setting is recommended

⁵ Contralateral risk-reducing mastectomy may be considered in patients with a high-risk for future breast malignancy (e.g., mutation carrier including *BRCA*, *PALB2*, and/or *CHEK2*, strong family history, history of chest wall radiation)

⁶ Tamoxifen is the primary choice for premenopausal patients, unless concerns for thromboembolism or history of uterine cancer/atypical hyperplasia. Starting dose of tamoxifen is 20 mg by mouth once daily; may reduce to 5 mg once daily if needed for patient tolerance.

⁷ Off-label (Not FDA approved), but evidence-based if tamoxifen is contraindicated or not tolerated

⁸ If patient is intolerant of tamoxifen, anastrozole, and exemestane (limited data in the use of exemestane), the use of letrozole may be considered

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

SURVEILLANCE/FOLLOW-UP

- Physical exam every 6 months up to 5 years from date of diagnosis, then annually thereafter
- Imaging recommendations for patients assigned female at birth and transgender women who have breast tissue:
 - Routine imaging with mammography or tomosynthesis of the chest wall or reconstructed breast following mastectomy is not indicated
 - Diagnostic mammography¹ with or without tomosynthesis at 6 months following completion of radiation therapy for patients with breast conservation therapy, then annually for the first 3 years, followed by annual screening mammography thereafter (see [Survivorship – Noninvasive Breast Cancer algorithm](#))
 - Consider additional MRI breast with and without contrast as indicated^{2,3,4}
- Assess for compliance with endocrine therapy and assess for toxicities if appropriate
- Postmenopausal patients receiving tamoxifen should have close monitoring for symptoms of uterine cancer or endometrial hyperplasia
- Assess bone health⁵ (see [Survivorship - Breast Cancer: Bone Health algorithm](#))
- Encourage age appropriate cancer and general health guidelines including sexual health/fertility
- Referral to Physical Therapy for upper extremity range of motion and muscle strength assessment
- Consider referral to Physical Medicine and Rehabilitation for radiation induced restricted range of motion unrelieved by physical therapy, to discuss additional strategies for improved physical functioning
- Consider referral to Plastic Surgery for discussion of surgical interventions to reduce radiation fibrosis or symptoms of breast lymphedema
- Patient education regarding symptoms including radiation therapy complications if appropriate

¹ Diagnostic mammography for up to 3 years post diagnosis then screening mammography thereafter

² Consider additional MRI breast with and without contrast annually for patients with germline mutations (see Appendix A in the [Breast Cancer Screening algorithm](#) for type of mutation and recommended screening interval). Alternating mammography and MRI breast every 6 months is suggested if feasible.

³ Consider additional MRI breast with and without contrast annually if diagnosis prior to age 50 years and have heterogeneously or extremely dense breasts. Alternating mammography and MRI breast every 6 months is suggested if feasible. This can be considered as delineated in the recommendation from the [American College of Radiology \(ACR\)](#) and the [American Cancer Society \(ACS\)](#). Note that the data supporting these guidelines are outdated (as per our internal analysis) and additional imaging is not recommended by the National Comprehensive Cancer Network (NCCN) survivorship guidelines. This approach is an active area of investigation within MD Anderson.

⁴ If there's a contraindication to MRI (e.g., lack of tolerance or access to MRI), may consider bilateral ultrasound breast or contrast-enhanced mammography (CEM)

⁵ All postmenopausal women (especially those on aromatase inhibitors)

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