INITIAL EVALUATION

Palpable mass greater than 2 weeks¹
- History and physical
- Bilateral mammogram with fetal shielding/ultrasound of breast and nodal basins

Core biopsy → Pathology
- ER/PR status
- HER2 status

Ductal carcinoma in situ² (DCIS)
Invasive Breast Cancer

See Ductal Carcinoma In Situ Breast Cancer Non-Invasive Algorithm
See Clinical Stages on Pages 2-3

Special considerations:
- There should be open communication with the patient, obstetrician, and medical, surgical and radiation oncologists.
- Surveillance of children exposed in utero to chemotherapeutic agents should be documented.
- Surgery will not be performed at MD Anderson post 23 weeks gestation.

¹ If metastatic disease at diagnosis, individualized treatment with multidisciplinary planning
² Patients with DCIS should not receive chemotherapy.
Is patient a candidate for post-operative systemic therapy?

Yes

- Individualized surveillance program based on clinical indication

No

- Individualized therapy based on multidisciplinary conference recommendation

Systemic therapy: anthracycline or taxane chemotherapy as medically appropriate once fetal age is greater than or equal to 12 weeks

Pathology review:
- ER/PR status
- HER2 status

Medical Oncology consult

Surgical consult for primary treatment

Maternal Fetal Medicine (MFM) consult to determine fetal age and delivery date

Surgical consult for primary treatment

MFM follow-up prior to each anthracycline chemotherapy every 3-5 weeks prior to taxane chemotherapy

- Consider holding chemotherapy by week 35 of gestational age or 3 weeks prior to a planned delivery

Response?

Yes

- Continue systemic therapy until completed

No

- Surveillance

Special Considerations:
- There should be open communication with the patient, obstetrician, and medical, surgical and radiation oncologists.
- Surveillance of children exposed in utero to chemotherapeutic agents should be documented.
- Surgery will not be performed at MD Anderson post 23 weeks gestation.

1 Anthracycline therapy prior to taxane therapy is the preference

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Clinical Stage II or III or suspicion of distant metastatic disease

Pathology review:
- ER/PR status
- HER2 status

Evaluate tumor response as clinically indicated, consider at least after 4 cycles of anthracycline-based chemotherapy or 12 cycles of taxane-based chemotherapy.

Individualized therapy based on multidisciplinary conference recommendation.

Surgical consult and Medical Oncology consult to determine preferred sequencing of systemic and local therapy.

Yes
- Continue systemic therapy until completed, followed by:
- Surgical resection, followed by:
- Radiation therapy (after delivery of baby)

No
- Surveillance

Yes
- Fetal age greater than or equal to 12 weeks?
- MFM follow-up prior to each anthracycline chemotherapy or prior to starting taxol and every 3-5 weeks during taxol therapy.
- Consider holding chemotherapy by week 35 of gestational age or 3 weeks prior to a planned delivery.

No
- Initiation of systemic therapy should be delayed until fetal age greater than or equal to 12 weeks.

Special Considerations:
- There should be open communication with the patient, obstetrician, and medical, surgical and radiation oncologists.
- Surveillance of children exposed in utero to chemotherapeutic agents should be documented.
- Surgery will not be performed at MD Anderson post 23 weeks gestation.
- Anthracycline therapy prior to taxane therapy is the preference.
- Following the delivery of baby:
  - Additional chemotherapy, endocrine, biologic therapy and/or radiation as clinically indicated.
  - Review labor, delivery, and neonatal records.

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SUGGESTED READINGS


**Invited Articles**


This practice algorithm is based on majority expert opinion of the Breast Medical Oncology Faculty at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

Olga N. Fleckenstein
Henry Mark Kuerer, MD
Jennifer Litton, MD
Vicente Valero, MD
Gloria Trowbridge, BSN, RN

* Clinical Effectiveness Development Team