Breast Cancer Risk Reduction Therapy

Risk Categories
Women 35 years old and older, and one of the following:
- History of lobular carcinoma in situ (LCIS)
- Atypical hyperplasia (AH) (ductal and lobular)
- Gail model 5-year breast cancer risk greater than or equal to 1.7%
- Tyrer-Cuzick model 10-year breast cancer risk greater than or equal to 5%
- Prior thoracic radiation therapy (XRT) at age 10-30 years old
- Life expectancy greater than or equal to 10 years
- No contraindications to risk reduction therapy

1Patients without breast prophylactic mastectomy (BPM)
2Limited data regarding risk reduction therapies in women with prior thoracic XRT
3Prior history of a thromboembolic event is an absolute contraindication. Adequately treated endometrial hyperplasia or early-stage endometrial cancer is not a contraindication to the use of tamoxifen.
4Lower risk of uterine cancer but less long-term benefit
5Limited data regarding AIs in women with proliferative breast lesions
6Off-label (Not FDA-approved)
7Tables that can be used to determine women for whom the benefits outweigh the risks can be found at Freedman AN, et al. (2011). Benefit/risk assessment for breast cancer chemoprevention with raloxifene or tamoxifen for women age 50 years or older. J Clin Oncol; 29:2327-2333.

Does patient meet criteria?

Pre-menopausal

- LCIS
- AH

Post-menopausal

- Tamoxifen

Assess balance of benefits and harms:
- Tamoxifen
- Aromatase inhibitors (AI) (exemestane or anastrozole)

Patient not a candidate for risk reduction treatment

Lifetime risk less than 20% by Gail or Tyrer-Cuzick models

Lifetime risk greater than or equal to 20%

Pre-menopausal

- Tamoxifen
- Raloxifene

Post-menopausal

- Aromatase inhibitors (AI) (exemestane or anastrozole)
Breast Cancer Risk Reduction Therapy

This practice algorithm has been specifically developed for MD Anderson using a multidisciplinary approach and taking into consideration circumstances particular to MD Anderson, including the following: MD Anderson's specific patient population; MD Anderson's services and structure; and MD Anderson's clinical information. Moreover, this algorithm is not intended to replace the independent medical or professional judgment of physicians or other health care providers.

SUGGESTED READINGS


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

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