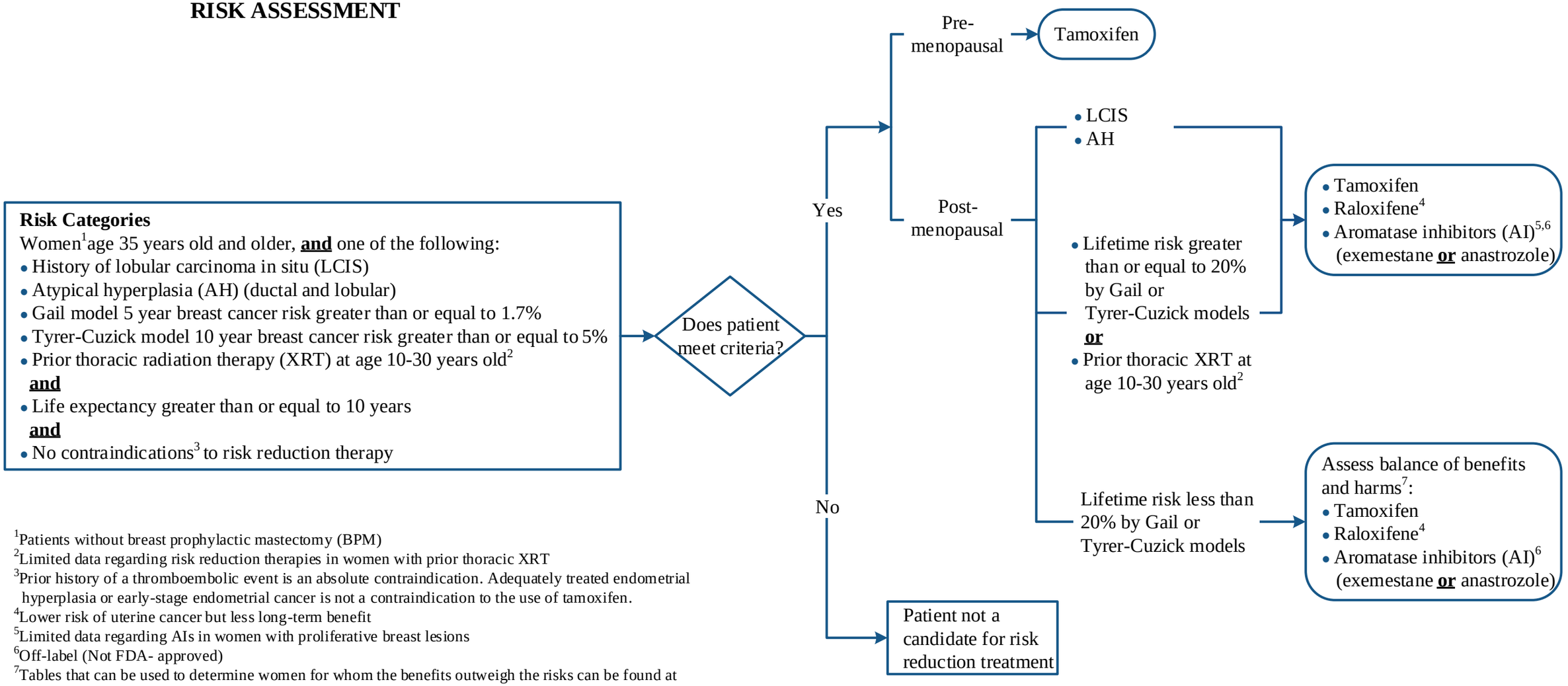
Breast Cancer Risk Reduction Therapy

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.

RISK ASSESSMENT



[1]Patients without breast prophylactic mastectomy (BPM)
[2]Limited data regarding risk reduction therapies in women with prior thoracic XRT
[3]Prior 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.
[4]Lower risk of uterine cancer but less long-term benefit
[5]Limited data regarding AIs in women with proliferative breast lesions
[6]Off-label (Not FDA- approved)
[7]Tables 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.

Department of Clinical Effectiveness V2
Approved by the Executive Committee of the Medical Staff on 08/29/2017

SUGGESTED READINGS

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DEVELOPMENT CREDITS

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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