South Yorkshire and Bassetlaw Integrated Care System
CANCER ALLIANCE
Working with Derbyshire

BREAST

Fast track Referral - 2 week wait

Please refer via e-Referral Service

Patient Details:

Patient Name			
Address			
DOB		**NHS No.**	
Home Tel. No.		**Gender**	
Mobile Tel. No.		**Ethnicity**	
Preferred Tel. No.		**Email Address**	
Main Spoken Language		**Interpreter needed?**	
Transport needed?		**Patient agrees to telephone message being left?**	
Communication requirements	Hard of hearing: ☐ Visually impaired: ☐ Learning/mental difficulties: ☐		
Date of Decision to Refer			

Registered GP Details:

Practice Name			
Registered GP		**Usual GP / Referring GP**	
Registered GP Address			
Tel No.		**Fax No.**	
Email		**Practice Code**	

The criteria are compliant with 2015 NICE guidelines for referring those with suspected cancer and not a substitute for your own clinical judgement or taking specialist professional advice as appropriate.

Type of Referral (please refer to symptom box on next page):

Breast Symptoms (to be seen within 2 weeks):

2ww	☐
Routine (Breast Symptomatic)	☐
Suspected or confirmed metastatic breast cancer	☐

Patient under 16 – Please refer to paediatrics

Family History only	☐	**Please refer to NICE CG 164 for referral Criteria**
Prosthetic Fitting Clinic only	☐	
Cosmetic/ Reconstruction only	☐	

Please obtain CCG funding approval for cosmetic procedures before referral

For Doncaster & Bassetlaw Patients Only: Do not use this referral form for a patient who has previously had confirmed breast cancer who is still under breast clinic review, who presents with a further lump or suspicious symptoms. Telephone 01302 642397 for Doncaster or 01909 572192 for Bassetlaw. The patient may also self-refer if still under follow up.
For Rotherham Patients Only: Do not use this referral form for a patient who has previously had confirmed breast cancer who is still under breast clinic review, who presents with a further lump or suspicious symptoms please contact the patients key worker telephone number available on the patient's treatment summary
For Barnsley Patients Only: Do not use this referral form for a patient who has previously had confirmed breast cancer who is still under breast clinic review, who presents with a further lump or suspicious symptoms please contact the Breast Care Nursing Team on 01226 432220 between 9:00 till 16:00 Mon to Fri.

DISCUSSIONS WITH PATIENT PRIOR TO 2WW REFERRAL

1. **Has the patient been advised that this referral is to exclude a cancer diagnosis and has a 2WW patient referral leaflet been given?** ☐
2. **Has the patient been given information on their actual appointment, time and place?** ☐
   Please see node on Map of Medicine Care Pathway
3. **Is the patient available for their appointment in the next 2 weeks and so they understand how important it is to let the practice know ASAP if they cannot attend?** ☐

2ww Suspected Cancer **Please only use this box if you feel this patient is LIKELY to have Breast Cancer**	**Yes**	**Symptomatic** Cancer NOT suspected (seen within 2 weeks)	**Yes**
Discrete, hard lump ±fixation, ± skin tethering	☐	Women aged <30 years with a lump – Please follow the Breast Lumps in young women pathway on ICE	☐
30 years and older with a discrete lump that persists post period/ menopause	☐	Patients with breast pain alone (no palpable abnormality) **Please don't refer until tried primary care management as cancer extremely unlikely (4-6 weeks regular NSAIDs or paracetamol as a minimum – see Best Practice Guidance). Antibiotics have no role in the management of breast pain without other sign of infection.** **Please Follow Pathway for Management and Investigation of Mastalgia (Appendix 1)**	☐
With **spontaneous unilateral bloody or blood stained** nipple discharge which stains clothes	☐	Asymmetrical nodularity or thickening that persists at review after menstruation	☐
With nipple retraction or distortion of recent onset (<3 months onset)	☐	Infection or inflammation that fails to respond to antibiotics	☐
Skin distortion/ tethering/ ulceration/ Peau d'orange	☐	With unilateral eczematous skin of areola or nipple: **please don't refer until tried topical treatment such as steroid cream for 2 weeks**	☐
Unexplained lump in axilla.	☐	Unilateral, spontaneous nipple discharge that is persistent or troubling	☐
Male breast lump where cancer is suspected **Please Follow Pathway for Management and Investigation of Gynaecomastia (Appendix 2)**	☐	Male Gynaecomastia **Please Follow Pathway for Management and Investigation of Gynaecomastia (Appendix 2)**	☐

Patients using progesterone based contraception may not have a regular period but they have an ovulatory cycle so review at a different time in the cycle is valid

For pathway management and investigation of mastalgia guidance – See breast pain pathway (Page 4)

Please do not refer patients with dermatological problems such as moles or dermatitis of the breast skin

Symptoms And Examination Findings:

Relevant Investigations:

Performance Status (Adult) A WHO classification indicating a PERSON's status relating to activity/disability:	Tick if criteria applies
0 - Able to carry out all normal activity without restriction	☐
1 - Restricted in physically strenuous activity, but able to walk and do light work	☐
2 - Able to walk and capable of all self-care, but unable to carry out any work. Up and about more than 50% of waking hours	☐
3 - Capable of only limited self-care, confined to bed or chair more than 50% of waking hours	☐
4 - Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair	☐

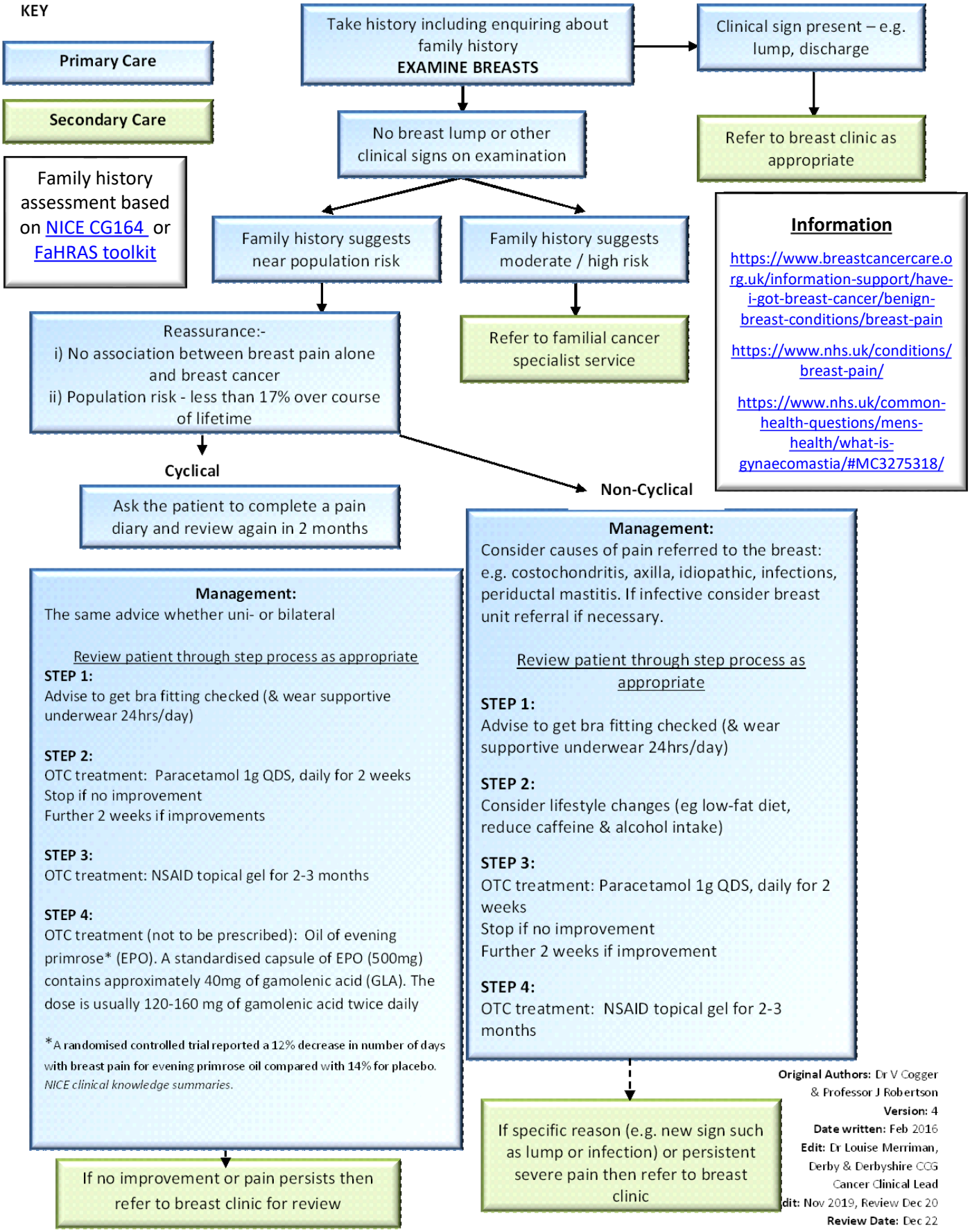
Past Medical History:

Current Medication:

Allergies:

Appendix 1

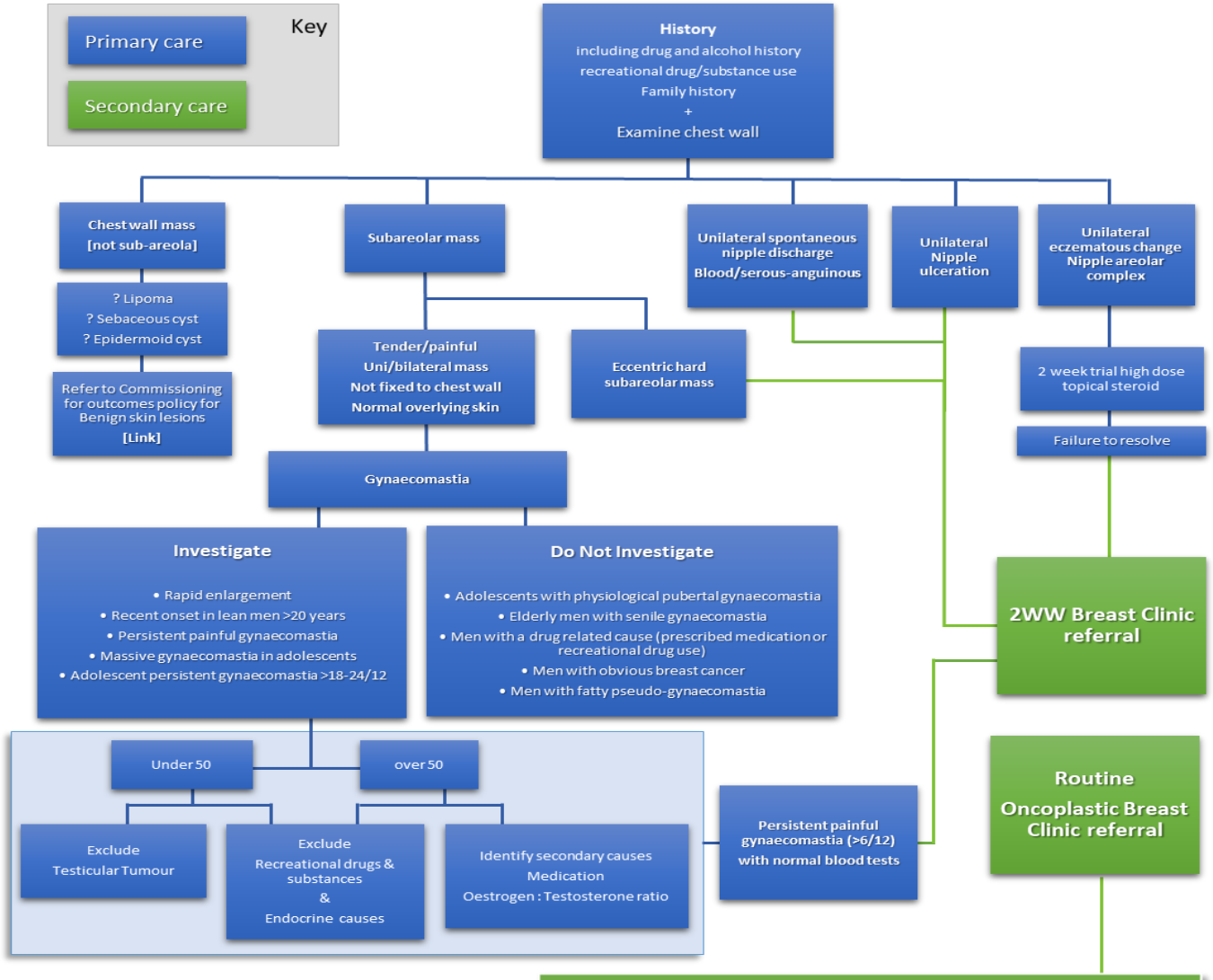
Pathway for the Management and Investigation of Mastalgia



Appendix 2

Pathway for the management & investigation of breast lumps in men

Male breast cancer is rare. It accounts for ~400 cases in the UK/year.
Most occur in men over 50 or younger men with very high risk family histories or known gene mutations.



Surgery for Gynaecomastia

Is only routinely funded when it is secondary to prostate cancer treatment

SY&B commissioners follow the existing local plastics policy which provides more comprehensive guidance on whether surgical corrective intervention may be funded after referral to the IFR panel.

If the patient has

- >100g of subareolar gland & ductal tissue (not fat)
- & a BMI between 18.5 - 27
- &/or been screened to exclude endocrine & drug related causes (if drugs have been a factor then 12/12 since last use should have elapsed)
- & has completed puberty (surgery is not routinely commissioned below age 19)
- & been monitored for at least 12/12 to allow for natural resolution if age ≤ 25

Primary care Gynaecomastia investigations

Age under 50s	Age 50 and over
BMI	
Medication review	
Testicular examination	
Testicular tumour markers α-Fetoprotein & ß-HCG	
TFTs & LFTs	
+ Hormone profile 9am Testosterone	
if abnormal LH & FSH SHBG Oestradiol Prolactin Albumin	
If abnormal refer 2WW to urology	If abnormal investigate & treat/refer
	If abnormal on two occasions refer to endocrinology

Causes of adolescent & adult male gynaecomastia

Age 70+ (Senile Gynaecomastia) Up to 65% due to relative reduction in testosterone to oestrogen

Prescribed drugs 10-20%

1. Oestrogen containing drugs eg. Bicalutamide, Buserelin, Goserelin
2. Androgen receptor blocking drugs e.g. Cyproterone acetate, spironolactone, flutamide
3. Androgen production inhibiting e.g. Finasteride, ketoconazole, dutasteride

Recreational drugs/substances Marijuana, amphetamines, heroin, methadone, anabolic steroids, Protein shakes

Pathological

1. Adrenal or testicular tumours <3% of gynaecomastia
a. Oestrogen or androgen producing tumours
b. Aromatase producing tumours
c. hCG producing tumours

2. Endocrine
a. Primary hypogonadism [10% of gynaecomastia]
b. Secondary hypogonadism
c. Prolactinoma
d. Thyrotoxicosis
e. Acromegaly
f. Androgen insensitivity

3. Systemic Illness
a. Liver cirrhosis
b. Renal failure
c. Malnutrition
d. Obesity
e. HIV

For further information see [abs-summary-statement-gynaecomastia-2019.pdf]

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Date Written: Dec 2020
Approved: Breast CDG, Jan 21

Document Control			
Version	Date	Author	Edit
Gynaecomastia Guidance	December 2020	L. Caldon,	Development of Gynaecomastia guidance
4.1	28/01/2021	L Horton, Julia Dicks, Kate Hodgkins	Lisa Caldon. Addition of Gynaecomastia guidance and associated amendments
4.2	12/02/21	L Horton	Amendment following CDG Feedback
4.3	01/03/21	L Horton	Updated following input from Julia Dicks
4.4	04/03/21	L Horton/ C Rogers	Minor changes following feedback from Primary Care
4.5	23/03/21	L. Horton	Minor modifications following feedback of L Caldon.

Reviewers

This document has been reviewed by the following:

Name	Title / Responsibility	Date	Version
All Members	Breast CDG	28/01/21	V4.1
Julia Dicks	CDG Chair	01/03/21	V4.2
All Members	Breast CDG	01/03/21	V4.3
Julia Dicks	CDG Chair	08/03/21	V4.4
MDT Leads	Breast CDG	09/03/21	V4.4
Julia Dicks	CDG Chair	23/03/21	V4.5