Royal Surrey Breast Unit, Guildford

Response to the licensing of anastrazole for the primary prevention of breast cancer in postmenopausal women with *no personal history of breast cancer*.

a. Background

Following the press coverage of the MHRA licence variation for anastrazole as primary prevention of breast in postmenopausal women we have received a significant number of enquiries from both primary care and individual patients. This statement sets out our approach and provides some clarity as to how we assess breast cancer risk to advise women on their screening and chemoprevention options.

The use of anastrazole to reduce the risk of breast cancer is not new but the licence variation was secured to provide more confidence in the use of the medication as a preventative medication and support more equitable uptake. It, along with tamoxifen and raloxifene, is one of three drugs recommended by NICE to reduce the risk of breast cancer.

b. How we assess risk

At the Royal Surrey Breast Unit all women referred to our family history service are asked to complete a standardised form which is then used to create a personal pedigree chart. Based on the ICR/RMH breast cancer screening guidelines we determine whether the individual is at higher risk of breast cancer and may be eligible for extra screening, chemoprevention or referral for genetic testing.

The four potential outcomes are;

1. Near population risk – no further intervention, advise to follow NHS standard breast screening
2. B1 risk – annual mammograms 40-50yrs and then NHS standard breast screening
3. B2 risk – annual mammograms 40-60yrs, a discussion of chemoprevention and then NHS standard breast screening after 60.
4. Referral to genetics – when the Manchester score indicates a risk of a BRCA 1/2 germline mutation of >10%. As part of this pathway a more detailed individual risk is calculated using CanRisk. This is then used to guide screening, chemoprevention and risk reducing surgery recommendations.

c. Who is a discussion of Anastrazole relevant to

Chemoprevention is discussed with any individual who is between 35 and 70 years of age and in the B2 screening category or who has been referred to the genetics service and is deemed appropriate for chemoprevention following a CanRisk assessment.

This discussion will include the benefits and side effects of the medication. The benefit equates to a risk reduction of developing a hormone sensitive breast cancer, estimated at 50% for anastrazole and 40% for tamoxifen. The side effects include menopausal symptoms (such as hot flushes and vaginal

dryness), an increased risk of osteoporosis with anastrazole, and an increased risk of DVT and endometrial/ womb cancer with tamoxifen.

It is important to note that although the rate of developing breast cancer is reduced this has not been shown to increase overall survival as many of these cancers are very treatable, particularly if diagnosed as part of a screening programme.

There are a number of clinical decision making aids which can be used to help women decide whether they want to take these medications.

Decision aid for postmenopausal women at moderately increased risk 16/11/2023 (nice.org.uk)

Decision aid for postmenopausal women at high risk 16/11/2023 (nice.org.uk)

d. How long do women take it for and when should they start

It is recommended that chemoprevention is taken for a maximum of 5 years. This is initially prescribed at the Royal Surrey with repeat prescriptions issued, in partnership with our GP colleagues, in the community.

It is not recommended that women start any form of chemoprevention under 35 years of age. Anastrazole is only indicated in the postmenopausal setting. After 70 years of age chemoprevention is not recommended as it is likely that the benefits will be outweighed by the risks.

e. Are there any women who shouldn't take Anastrazole in this context

We would not recommend anastrazole if;

- There is an established diagnosis of osteoporosis, we would recommend a bone density scan prior to starting Letrozole. If so then suggest they consider tamoxifen or raloxifene instead.
- The individual is on HRT
- They have had risk reducing mastectomies.

f. What do I do if a patient asks about anastrazole

- If they have been previously assessed at the Royal Surrey (or elsewhere) and have been offered annual mammograms to 60 years of age then refer them via ERS to the family history service.

- If they have not been previously referred but have a significant family history then refer them for assessment. A significant family history may include;

    - A **single** first degree relative with breast cancer <40, bilatateral breast cancer, male breast cancer or a history of breast and ovarian cancer
    - Two or more first or second degree relatives with breast cancer

If they have been assessed previously and were either offered annual mammograms to 50 or standard breast screening then **please check their family history hasn't changed and if not** they do not require re- referral as we would not offer them chemoprevention.

If it is not clear what assessments they have had in the past then the advice and guidance pathway can be used for clarification.

g. What else can women do to reduce their risk

There are a number of recognised lifestyle risk factors which are associated with an increased risk of breast cancer. Supporting women to achieve a healthy weight, drink less alcohol and partake in regular exercise should be encouraged.

We would promote regular breast examination and the uptake of screening mammograms via the NHS breast screening programme.

h. Where can I find more information

There are some excellent resources available including;

Breast Cancer Now leaflets, an NHS England e-learning module, NICE decision making aids and UK Cancer Genetics Group patient information leaflets.

This can all be found at https://www.royalsurreybreastunit.com/family-history.html

Mr JD Horsnell, Consultant Oncoplastic Breast Surgeon

On behalf of the Breast Surgery Team, RSCH

Feb 2024