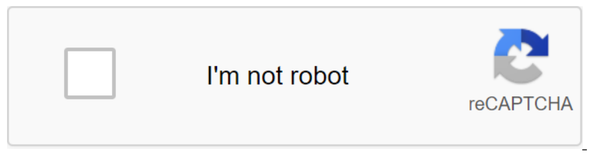
Nice guidelines for brca testing



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FREE subscription for doctors and students... Click herey-3 pages of open access. A guide to the referral of women with a history of family breast cancer has been prepared by NICE (1). When considering referral decisions, attempts should be made to gather as accurate information as possible on: the age of diagnosis of any cancer in the location of relatives of multiple cancers (including bilateral disease) of Jewish origin Carrier probability, in which genetic testing should be offered If available in secondary care, use a method of calculating the probability of the carrier with demonstrated acceptable performance (in calibration and discrimination), as well as family history, to determine who should be offered in the case of the genetic clinic. Examples of acceptable methods include BOADICEa and Manchester's scoring system offering genetic testing in specialized genetic clinics to a relative with a personal history of breast and/or ovarian cancer, if this relative has a combined BRCA1 and BRCA2 probability of carrier mutation 10% or more offer genetic testing in specialized genetic clinics for a person without a personal history of breast or ovarian cancer, if their combined BRCA1 and BRCA2 are likely to mutate10% or more, and the affected relative is unavailable for breast cancer risk testing near the risk of a moderate risk of high risk - Lifetime risk of 20 less than 17% less than 17%, but less than 30% 30% or more risk between the ages of 40 to 50 Less than 3% 3-8% More than 8% , BRCA2 and TP53 mutations and rare conditions that carry an increased risk of breast cancer Such as Peutz-Jeger Syndrome (STK11), Cowden (PTEN) and Family Diffuse Stomach Cancer (E-Cadherin) Observation of Women Without Personal Breast History Cancer Offer Annual Mammography Surveillance for Women: Aged 40-49 Years With Moderate Risk of Breast Cancer At 40-59 Years With High Risk of Breast Cancer, but with a 30% or lower probability of being a BRCA or TP53 carrier aged 40-59 years that did not have genetic testing, but have more than 30% chance of being a BRCA carrier aged 40-69 years with the famous BRCA1 or BRCA2 mutation offering annual MRI observations for women: at age 30-49 years who have not had genetic testing but have more than 30% chance of being a BRCA carrier at age 30-49 years old with a known BRCA1 or BRCA2 mutation at the age of 20-49 who have not had genetic testing but have more than 30% probability of being a carrier of TP53 aged 20-49 years with the known mutation TP53 Observation for women with a personal and family history of breast cancer offer annual mammography surveillance for all women aged 50-69 with a personal history of breast cancer that: remain at high risk of breast cancer (including those who have the BRCA1 or BRCA2 mutation), and do not have TP53 mutations to offer an annual MRI MRI for all women aged 30-49 years with a personal history of breast cancer who are still at high risk of breast cancer, including those who have BRCA1 or BRCA2 mutations of chemoprophylaxis for women without a personal history of breast cancer offer either tamoxifen or rotoxyphen for 5 years in postmenopausal women with a uterus and high risk of breast cancer, If they do not have a past history or may be at increased risk of thromboembolic disease or endometrial cancer Risk reduction mastectomy for women without a personal history of breast cancer all women considering a bilateral risk of lowering mastectomy should be able to discuss their breast reconstruction options (immediately and delayed) with a member of the surgical team with a specialist oncoplastic or breast reconstructive skills women are considered at near risk for the population in primary care. The criteria for determining when a woman is near risk to the public and suitable for management in primary health care are defined in the related paragraph below. Reference: Last reviewed 01/2018 Links: Page 1 of 19 This summary only covers recommendations for primary health care. Please see the full guide to complete guidance on: caring for people in secondary care and specialized genetic clinics for genetic monitoring testing and early breast cancer detection strategies. This resume has been shortened for print. The full summary will look at guidelines.co.uk/238727.article. When a person without a personal history of breast cancer presents with breast symptoms or has concerns about relatives with breast cancer, first and second degree family history should be taken into primary care to assess the risk because it allows appropriate classification and care medical professionals to respond to a person, which presents with problems but should not, in most cases, actively seek to identify people with a family history of breast cancer In some cases, it may also be clinically relevant to adopt a family history, for example, for women over 35 years of age using oral contraceptive pills or for women who are considered for long-term hormone replacement therapy (HRT) to use a person should be able to discuss concerns about their family history of breast cancer If it rises during a second-degree family history consultation (i.e., including aunts, uncles and grandparents) should be taken into primary care before explaining the risks and options for second-degree family history to include paternal as well as maternal relatives asking people Your family history with relatives is useful in collecting the most accurate information tools such as family history questionnaires and computer packages there that can help accurate collection of family legal information, and they should be available for referral decisions, attempts should be made to gather as accurate information as possible The age of diagnosis of any cancer in relatives where multiple cancers (including bilateral diseases) of Jewish origin A Effective care includes a balanced partnership between patients and health care providers. Patients should be able to make informed choices about any treatment and care and participate in decision-making To ensure patient-professional partnerships, patients should be offered individually based on information, including information about sources of support (including local and national organizations) Tailor information should take into account the format (including whether written or tapes), as well as the actual content and form, which should be provided (see Information provision for people concerned with family risk of breast cancer) Standard information should be and agreed at the national level if possible (NICE information to the public provides a good starting point) Standard information should not contradict messages from other service providers, including generally accepted information on human settlements Information Concerned family risk of breast cancer can be found on guidelines.co.uk/238727.article Standard Written Information for All People Risk Information about Population Level and Family History Risk Level, including the Definition of Family History Post that if their family history changes, their risk may change information about breast health awareness lifestyle tips regarding breast cancer risk, Including information on: HRT and oral contraceptives (women only) lifestyle, including diet, alcohol, etc. breastfeeding, family size and timing (women only) Contact data of those who provide support and information, including local and national support groups People should be informed prior to appointment that they can bring a family member/friend with them to the reception Detailed information about any tests or studies that may be appropriate for people being cared for in primary health care Standard written information (as above) Advice to return, to discuss any impact if there is a change in family history or breast symptoms develop For people called secondary care Standard written information (as above) Information about risk assessment exercises that will take place and advice on how to get a comprehensive family history, if information is required on potential outcomes, depending on the results of the risk assessment (including referral back to primary care, management within secondary care or referral to a specialist Every level For people who are referred back to Primary Health Care Standard Written Information (as stated above) Details on why secondary or specialized genetic services do not need counseling to return to primary health care to discuss any impact if there is a change in family family or breast symptoms develop People without a personal history of breast cancer can be cared for in primary care if family history shows only one first-degree or second-degree relative diagnosed with breast cancer over the age of 40, provided that none of the following are present in family history: bilateral breast cancer of male breast cancer ovarian cancer Jewish origin sarcoma in relative age before 45 years of glioma or childhood adrenal cortical carcinoma complex models of multiple cancer in young age fathers Breast Cancer History (two or two or more relatives on the father's side of the family) People who do not meet the criteria for referral should be cared for in primary health care by providing standard written information to women who are referred to secondary care or a specialized genetic clinic should be provided with written information on whether what happens at this stage support mechanisms (e.g., risk counseling, psychological counseling and risk management advice) should be identified and should be offered to women who are not eligible for referral and/or follow-up based on age or risk level who have ongoing support problems necessary for primary health care to care for women with a family history of breast cancer. The basic requirements for supporting primary health care are: a single point and a locally agreed referral mechanism for women who have been found to be at increased risk of training materials on family breast cancer support systems, standardized patient information leaflets assigned by secondary health care contacts to discuss the management of unspecified cases where people should be provided with standardized written information about risk, including age as a risk factor, to be discussed On a case-by-case basis in appropriate care settings Menstrual and Reproductive Factors Medical Professionals should be able to provide information on the effects of hormonal and reproductive factors on the risk of breast cancer Advice for women under 35 years of age with a family history of breast cancer should be in accordance with general health advice on the use of oral contraceptive pills women over 35 years of age with a family history of breast cancer should be informed about the increased risk of breast cancer , given that their absolute risk increases with age for women with BRCA1 mutations, the conflicting effects of a potential increased risk of breast cancer age under 40 and lifelong protection against the risk of ovarian cancer from taking oral contraceptive pills should be discussed women should not be prescribed oral contraceptive pills solely for cancer prevention, although in some situations the reduced risk of ovarian cancer may outweigh any increase in the risk of breast cancer if a woman has a BRCA1 mutation mutation Given the reduced risk of anophorectomy before the age of 40, oral contraceptive pills should not be prescribed solely to reduce the risk of ovarian cancer women should be advised to breastfeed if possible because it may reduce the risk of breast cancer, and according to general health boards of women with a family history of breast cancer, who are considering taking, or already taking, HRT should be informed of the increased risk of breast cancer with the type and duration of HRT advice for individual women on the use of HRT should vary depending on individual clinical circumstances (such as symptoms of amptomy menopause, age, severity of menopause symptoms, or osteoporosis) the use of HRT in a woman with family risk should be limited as little as possible. Estrogen-only HRT should be prescribed where possible a woman with early (natural or artificial) menopause should be informed about the risks and benefits of HRT, but overall the use of HRT should be limited to women under 50 years of age if moderate or high-risk alternatives to HRT should be considered for specific symptoms such as osteoporosis or menopause symptoms Consideration should be given to a type of HRT if it is considered for use in conjunction with the risk of reduced gynecological surgery Additional information on risk reduction and treatment strategies can be found in guidelines.co.uk/238727.article. Alcohol consumption of women with a family history should be informed that alcohol can increase the risk of breast cancer slightly. However, this should be considered in conjunction with any potential benefits of moderate alcohol consumption on other conditions (such as heart disease) and adverse effects, Related to excessive alcohol consumption Smoking women should be advised not to smoke, according to current health boards Weight and physical activity women should be informed of the likely increase in postmenopausal risk of breast cancer from overweight women should be informed of the potential benefits of exercise at risk of breast cancer Terms used in this guide of first-degree relatives of father, daughter, son, sister, brother of second degree relatives, grandson, aunt, uncle, niece, nephew, half sister, half-brother of a woman of Jewish descent are about 5-10 times more likely to carry mutations of BRCA1 or BRCA2 than women in non-Jewish populations, this will equate to less than 3% 10-year risk of breast cancer at age 40   Published: June 2013 Last updated: November 2019 2019.