# Oncology

ARIMGSAS 12 week AMC Clinical Course

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# Case 1

38 year old Harry, presents to your GP clinic. He has a painful rash on his abdomen since yesterday and is concerned. He works in childcare.

Tasks:

1. Take a history from the patient
2. Ask for the relevant PEFE
3. Explain the condition and cause to him

## History

*PC* - painful rash over abdomen

*HPC*

- Duration: - 2 days
- Onset: - sudden or gradual? come and go? or always there?
  - getting worse? better? same?
  - 1st time? recurrent? tried any topical treatments?
- Site: - abdomen, anywhere else? any pattern?
  - can you describe it? (colour, shape), can you feel it?

- Assoc symptoms: - itchy? bleeding? discharge?
  - blisters? (Yes)



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## *DD questions* *

- *<u>Conditions with skin blisters</u>*

  - Chicken pox: - had chicken pox before?
    - vaccinated against chicken pox?
    - contact history?
  - Eczema herpeticum: - do you have eczema?
  - Skin infections: - eg scalded skin syndrome
    - any fever? any skin infections?

- *<u>Conditions with immunosuppression</u>*

  - Lymphoma: - any LOW, LOA, L&B? + night sweats?
  - Malignancy: - any LOW, LOA, L&B? + bone pain? (mets)
    - blood in stool/urine? change in bowel habits?

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- HIV: - any chronic illness affecting immunity, like HIV?
- Splenectomy: - any operation to remove spleen?
- DM: - any increased thirst or urine? any diabetes?

*PMH*
- any type of cancer before?

*FH*
- blistering skin disorders?
- family history of cancer?

*Sexual History*
- are you sexually active? stable partner? diagnosed with STI before?

*SADMA*
- smoking?
- medications - steroids, immunosuppressants, chemo?

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## Physical Examination Focused Examination (PEFE)

- VS: T, PR, BP, RR, SaO2 BMI
- GA: alert & comfortable or ill & lethargic
- GE: palor, jaundice, cyanosis, clubbing

- Local examination of rash:
  - site, size, shape
  - colour, configuration, borders,
  - primary lesion - morphology? macule, papule or vesicle?
  - any secondary lesions? (excoriations, scales)

- Systemic examination
  - CVS, Respi, Abdo
  - Lymph nodes

## Positive findings

- red rash since yesterday
- distribution from back to front on tummy
- very sore, painful
- very tired for last 2 months
- has night sweats
- lost 8 kg in last 3 months - unintentional
- has had chicken pox in the past
- PEFE:
  - rash extending around from back towards abdo, vesicles,
  - dermatomal distribution
  - splenomegaly
  - cervical and axillary lymphadenopathy (rubbery)

## Explanation

- You have a condition called shingles, caused by virus called varicella zoster.
- When you had chickenpox in the past, the virus entered your body and remained there silently in the nerve roots.
- This usually causes no problems. But under physical or psychological stress this virus can reactivate.
- When your immunity, or the defence mechanism of your body becomes weak, this causes reactivation of the virus and the rash. It is a viral infection and requires treatment.

- However, what I am concerned about is the reason why you have the rash right now. In other words: the reason behind the weakening of your immune system.

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- Causes can be medications like steroids or DM or when the spleen is removed or HIV infection or cancer.

- Also, on examination, I found an organ called spleen to be enlarged, as well as some rubbery lymph nodes in your neck and armpits. This (in combination with your night sweats, LOA and LOW) makes me concerned about a form of blood cancer called lymphoma.

- I am not saying you definitely have cancer, but it is something I am concerned about. What we must do is find out what is causing your weak immunity and so we need to do further investigations.



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## Management

- Pain relief - paracetamol, NSAIDs, (amitriptyline)
- Antivirals to reduce progression of condition
- Exclusion from child care until blisters heal, certificate for leave
- Notifiable condition
- Vaccination of contacts within 72 hours
- VZIG within 96 hours (neonates, pregnant and immunocompromised)
- Discuss with supervisor to consider ED referral
- Refer urgently to haematologist for hospital management

- Blood investigations - FBE, PBF, ESR, CRP, UEC, LFT, TFT, FBG
  HIV test with consent
- Lymph node biopsy - after numbing the area with LA, a needle will be introduced and some cells or tissue will be taken to examine under the microscope.

## Conclusion

- I know it must be scary to hear that cancer could be the possibility here but…
- …LET ME REASSURE YOU…
- I will be here to support you during these investigations.
- If at anytime you have any questions, please feel free to come and ask me.

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# Case 2

You are a GP and 30 yo Aria came to you 2 weeks ago. Your colleague has arranged some investigations including an ultrasound and FNAC. The results are with you and show papillary carcinoma of the thyroid.

Tasks:

1. Explain diagnosis to patient
2. Discuss management options

## Breaking bad news: SPIKES

*S*etting

- Build rapport and explain results. "*How are you doing today? How is the biopsy site? Any pain, discharge or bleeding?"*
- *"Before we proceed, I'll just make sure there are no interruptions, my phone is on silent and calls to my room are diverted."*

*P*erception

- Explore what's in their mind such as concerns. "*I have the test results with me. Before we discuss it, do you have any perceptions or expectations about the results?"*

*I*nvitation

- *"Is someone here with you? Or are you alone today? Do you want me to call someone in while we discuss the results?"*
- *"Are you ok for me to go through the results now?"*

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*Knowledge*

- Delivering the news to them that they have cancer.
- *"Unfortunately I do not have good news for you today. The little piece of tissue that was taken from the thyroid shows that you have cancer."*

*Emotion*

- **PAUSE**. Give some time to the patient to take in the news (5 sec).
- Wait for the role player to react. Let them cry and yell first and then continue.
- show empathy and support. *"I know this must come as a shock."*
- *"Can I offer you tissue, can I offer you glass of water?"*
- *"Are you okay for me to continue? I know this is quite a lot to take in. Do you want me to continue the consultation or do you want me to arrange another consultation?"*
- ask again: *"Do you want me to call someone to be with you?"*

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*Strategies*

- Let me try to explain it to you step by step. If you don't understand anything please stop me at anytime.

- Your thyroid is the butterfly shaped gland in your neck. The type of cancer you have is called papillary carcinoma of the thyroid. It is the most common type of thyroid cancer.

- Prognosis refers to the expected outcome of a disease. It is not possible for me to predict the exact course of the disease for you specifically right now with 100% certainty. An individual's prognosis depends on the type and stage of cancer, as well as their age and general health at the time of diagnosis.

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- Generally, the earlier thyroid cancer is diagnosed, the better the outcomes. And the type you have overall responds well to treatment.

- Before we go on further, we need to do more investigations to find out whether the cancer is just in the thyroid or has spread to anywhere else. We need to do some blood investigations and imaging such as CT-scan head, neck and chest, abdomen (for staging). If the cancer hasn't spread anywhere else, then the prognosis is good.



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## Management

- You will be treated by an MDT team of specialists including the thyroid surgeon, specialist oncologist, radiotherapist, cancer nurse, as well as myself as your GP. First of all, we need to find out at what stage the cancer is. We will do so by carrying out some blood tests and the scans I mentioned before.

- The most likely management includes surgical removal of the whole or part of the thyroid gland. This is called thyroidectomy. If nearby lymph nodes are involved then the affected lymph nodes are removed.

- After the surgery you might get extra treatment, called radioactive iodine, to kill off any remaining cancer cells in the body. After these procedures, we may need lifelong thyroid hormone replacement with the help of thyroxine tablets. The physician will explain to you about thyroxine treatment later on.

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- You will need to come for regular follow-ups after surgery, where we will be doing regular blood tests and scans of the neck for monitoring.

- The 5-year survival rate after treatment is 80-95% for papillary carcinomas. The poor prognostic factors are being male, older age, if tumour is larger than 1 cm, if it is poorly differentiated, if local or distant spread has occurred.

- If you feel you cannot cope with the stress, please contact me or the hospital at any time. We can manage the stress with the help of CBT or talk therapy as well as social support through support groups.

- If you like, I can arrange a family meeting for further discussion, so your family can also support you.

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# Case 3

45 year old Hannah comes to your GP clinic for biopsy results. Previously she complained of abdominal pain. Colonoscopy was done and biopsy of a growth 10 cm from the anal verge shows adenocarcinoma. Her father died of bowel cancer at the age of 60.

Tasks

1. Explain results and condition to the patient
2. Explain your investigations with with reasons
3. Explain management to patient

## Breaking bad news: SPIKES

*S*etting

- *"How are you doing today? "Before we proceed, I'll just make sure there are no interruptions, my phone is on silent and calls to my room are diverted."*

*P*erception

- *"I have the test results with me. Before we discuss it, do you have any perceptions or expectations about the results?"*

*I*nvitation

- *"Is someone here with you? Or are you alone today? Do you want me to call someone in while we discuss the results?"*
- *"Are you ok for me to go through the results now?"*



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*Knowledge*

- *"Unfortunately I do not have good news for you today. The little piece of tissue that was taken from your rectum shows that you have cancer."*

*Emotion*

- **PAUSE**. (5 sec).
- show empathy and support. *"I know this must come as a shock."*
- *"Can I offer you tissue, can I offer you glass of water?"*
- *"Are you okay for me to continue? I know this is quite a lot to take in. Do you want me to continue the consultation or do you want me to arrange another consultation?"*
- ask again: *"Do you want me to call someone to be with you?"*

==========

*Strategies*

- Let me try to explain it to you step by step. Your rectum is the last part of you gut just before your back passage. The type of cancer you have is called adenocarcinoma of the rectum also known as bowel cancer. It is the most common type of bowel cancer. It starts in the lining of your bowel. (Draw diagram)

- Prognosis refers to the expected outcome of a disease. It is not possible for me to predict the exact course of the disease for you specifically right now with 100% certainty. An individual's prognosis depends on the type and stage of cancer, as well as their age and general health at the time of diagnosis.

- *“Are you with me so far?”*

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- Generally, the earlier bowel cancer is diagnosed, the better the outcomes. If it grows bigger it can cause obstruction causing severe pain and constipation. If this persists, it can lead to further distension and rupture making it life threatening. Treatment is required to avoid this. (Draw diagram)

- Therefore, we need to do more investigations to find out whether the cancer is localised or has spread to anywhere else. This is called staging. We need to do some blood investigations and imaging. If the cancer hasn't spread anywhere else, then the prognosis is better.

- This information will also help your treating team to advise on the best treatment options.



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## Investigations

- Blood test
  - specific - tumour markers eg CEA
  - general - FBE, UEC, LFT, fasting blood glucose

- Imaging
  - for staging
  - CT chest & abdomen
  - bone scan

## Management

- MDT approach
    - oncologist, colorectal surgeon, cancer nurse, GP

- Elective surgery is mainstay of treatment
    - cutting out tumour till margins clear
    - then re-attach ends of bowel

- Temporary stoma bag and adjuvant chemotherapy may be needed
    - if decision is for re-attachment at another later operation

- Family meeting and screening of relatives (1st degree)
- Support group
- Councillor or psychologist to cope with disease (if needed)
- Reading material

## Screening

- *Low risk**
  - 1 x FDR (>55 years) or no family history
  - FOBT, 2 yearly, age 50-74

- *Moderate risk **
  - 1 x FDR (<55 years) or 2 x FDR (any age)
  - FOBT, 2 yearly, age 40-49
  - Colonoscopy, 5 yearly, age 50-74

- *High risk*
  - 3 x FDR (any age) or 3 x FDR/SDR (at least one <55)
  - FOBT, 2 yearly, age 35-44
  - Colonoscopy, 5 yearly, age 45-74
  - Refer family cancer clinic

## Management (for advanced ca)

*alternative scenario*

- When bowel cancer has spread to the liver, lung or lining of the abdomen and pelvis (omentum and peritoneum), this is known as advanced or metastatic (stage 4) bowel cancer. To control the cancer, slow its growth and manage symptoms such as pain, you may have a combination of chemotherapy, radiation therapy, targeted therapy and surgery.

- Palliative treatment helps to improve people's quality of life by managing the symptoms of cancer without trying to cure the disease. It is best thought of as supportive care.

- Many people think that palliative treatment is for people at the end of their life, but it may help at any stage of advanced bowel cancer. It is about living for as long as possible in the most satisfying way you can.

- Palliative treatment is one aspect of palliative care, in which a team of health professionals aim to meet your physical, emotional, practical, social and spiritual needs.

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# Case 4

70 year old Howard comes to your GP clinic, expecting his biopsy results today. A biopsy was taken, of a suspicious skin lesion on his right arm and showed superficial spreading melanoma of 0.6 mm thickness.

Tasks:

1. Explain the results and condition to the patient
2. Counsel accordingly

## Breaking bad news: SPIKES

*S*etting

- *"How are you doing today? How is the biopsy site? Any pain, discharge or bleeding?"*
- *"Before we proceed, I'll just make sure there are no interruptions, my phone is on silent and calls to my room are diverted."*

*P*erception

- *"I have the test results with me. Before we discuss it, do you have any perceptions or expectations about the results?"*

*I*nvitation

- *"Is someone here with you? Or are you alone today? Do you want me to call someone in while we discuss the results?"*
- *"Are you ok for me to go through the results now?"*

==========

*Knowledge*

- *"Unfortunately I do not have good news for you today. The little piece of tissue that was taken from your skin shows that you have cancer."*

*Emotion*

- **PAUSE**. (5 sec).
- show empathy and support. *"I know this must come as a shock."*
- *"Can I offer you tissue, can I offer you glass of water?"*
- *"Are you okay for me to continue? I know this is quite a lot to take in. Do you want me to continue the consultation or do you want me to arrange another consultation?"*
- ask again: *"Do you want me to call someone to be with you?"*

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***Strategies***

- Let me try to explain it to you step by step. Your skin is considered the largest organ of the body. The skin cancer you have is called melanoma and the type of melanoma you have is called superficial spreading melanoma. This means that the cancer does not go too deep into the skin. (Draw diagram)

- Prognosis refers to the expected outcome of a disease. It is not possible for me to predict the exact course of the disease specifically for you right now with 100% certainty. An individual's prognosis depends on the type and stage of cancer, as well as their age and general health at the time of diagnosis.

- Generally, the earlier melanoma is diagnosed, the better the outcomes. Also because yours is superficial, the outcome is better.

- *“Are you with me so far?”*

- Melanomas are measured by the thickness or depth, yours is 0.6 mm. The reason why this is important is that it gives us a general idea about the outcome. When it is less than 0.75 mm thickness, there is less chance to spread to nearby lymph nodes and the outlook is good (SLN biopsy if =/> 1mm).

- Melanoma is a very common type of cancer in Australia. Risk factors include high levels of sun or UV exposure, sunburn, excessive number of moles, fair skin and a family history.

- If it has not spread anywhere else the prognosis is good.

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- We will take care of you as a MDT: I will be your GP and dermatologist and cancer specialist will be involved.

- The specialist might need to do some investigations including CT scans and bone scans to check that it hasn't spread.

- Mainstay of treatment is surgery: I will refer you to the surgeon who will ensure that A SAFE MARGIN has been cut out if it has not already been done, which will most likely be 1 cm in your case.

- If patient says they removed it already, say: “Yes but that was for biopsy and we were not sure what it was. Now we know what it is, we must make sure a safe margin has been cut out, so that there is less chance of melanoma cancer cells left behind and spreading later on.

- Afterwards, the specialist will decide whether any further management such as radiotherapy or chemotherapy is needed.

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Table 1. Melanoma wide excision margins (after initial excision biopsy) recommended in the Clinical Practice Guidelines for the Management of Cutaneous Melanoma in Australia and New Zealand[3]

| Breslow thickness* | Surgical margin |
|---|---|
| Melanoma in situ | 5 mm |
| Melanoma <1.0 mm | 1 cm |
| Melanoma 1.0–4.0 mm | 1–2 cm* |
| Melanoma >4.0 mm | 2 cm |
| * For melanomas 2–4 mm thick, it may be desirable to take a 2 cm margin where possible | |

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# Case 5

58 year old Theo has been to the urologist who told him he has prostate cancer. He comes to you to discuss his investigation results.

- MSU showed E. coli
- PSA 6 (<4 is normal)
- Biopsy shows adenocarcinoma, carcinoma cells confined to prostate capsule
- Gleason score 7
- Cystoscopy showed no outflow obstruction of bladder neck
- Bone scan shows no metastases
- CT chest/abdomen shows no metastases

Tasks:

1. Explain results
2. Explain implications
3. Explain management options

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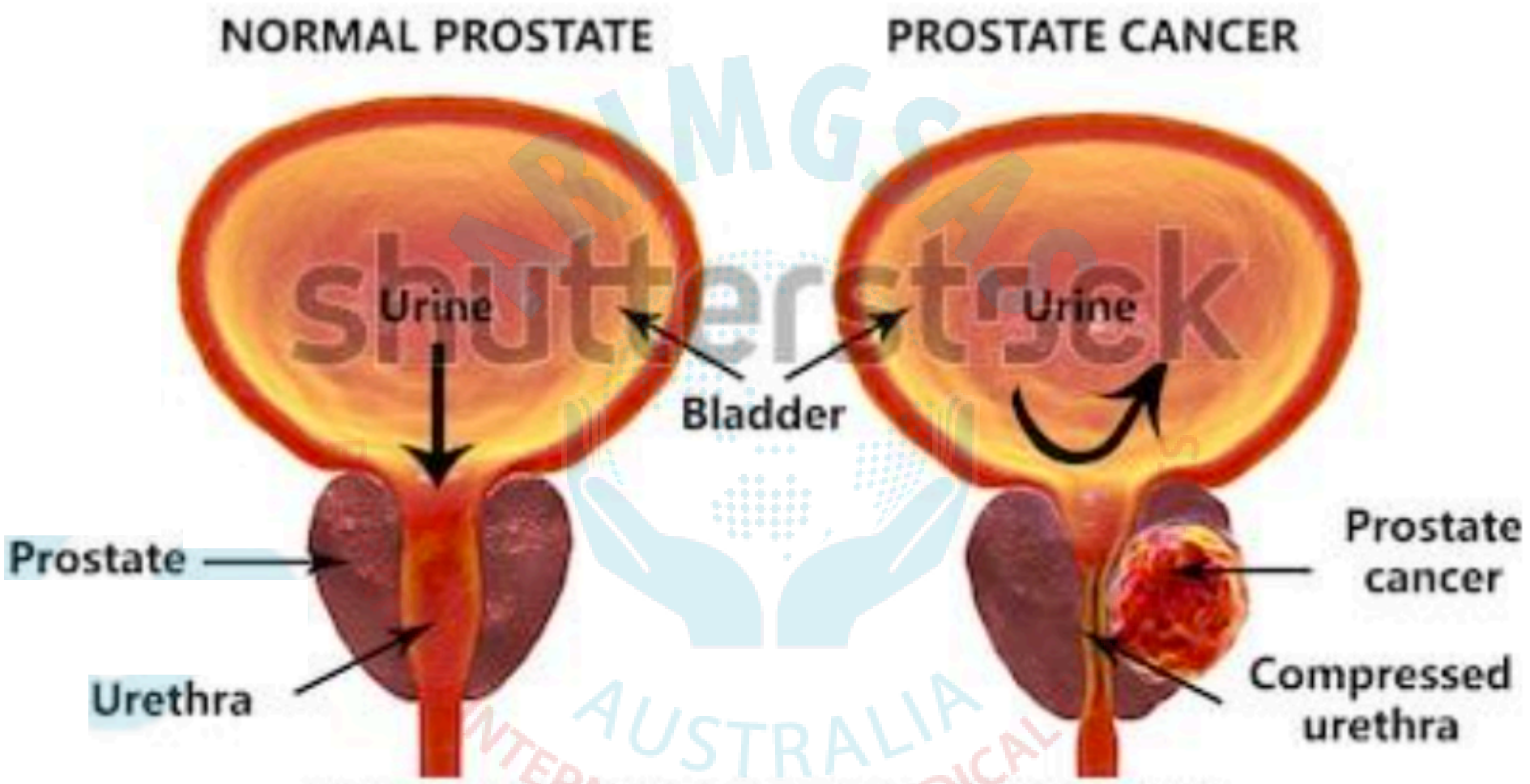
## Explain the results

- I appreciate you have come for the results.
  I am sorry to hear that have prostate cancer.
  May I ask what your symptoms were before you got this diagnosis?

- Let's go through the results together, if you have any doubts or questions, please do not hesitate to stop me.

- (Draw diagram of bladder and prostate.)
  This is the bladder, a bag where urine is collected.
  At the neck there is a small walnut shaped gland called the prostate.
  It is part of the male reproductive system.
  In your case there is cancer in this gland.


NORMAL PROSTATE
PROSTATE CANCER
Urine
Bladder
Urine
Prostate
Urethra
Prostate cancer
Compressed urethra

- MSU means mid-stream urine: a urine sample of yours was taken to look for abnormalities. It shows E. coli, which is a bug. This implies that you have a bacterial infection or a UTI, urinary tract infection.

- PSA is a prostate specific antigen. This blood test is a screening test to give an indication whether something is happening with the prostate. Normally it is less than 4, in your case it is 6.

- A biopsy was taken from the prostate, meaning tissues from some parts of the gland were taken and examined under the microscope for abnormalities. This confirms that you have cancer. The type of cancer is adenocarcinoma, please do not worry about that, it is just a name of the type.



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## Implication

- The biopsy also shows that the prostate is confined within the prostate capsule which means it is within the gland and has not spread as prostate cancer sometimes does.

- The Gleason Score is a scoring system done specifically for this type of cancer from 2 to 10 to show how aggressive the cells are.
  2 is least aggressive while 10 is most aggressive.
  Your score is 7 which is intermediate.
  This is something I am a little concerned about at this point, because this result implies that the cells could be moderately aggressive.

- A cystoscopy was done where a flexible tube with a camera was passed through the urinary tract to see the bladder.
  This shows no obstruction of flow meaning no difficulties in passing urine. If the tumour is large enough sometimes it can compress (draw) leading to obstruction of the flow of urine.
  This implies that the cancer may be a small one, so that is some good news.

- A bone scan is a special test to check if the cancer has spread anywhere into your bones. Because this type of cancer generally spreads to the bones. Your bone scan showed that there is no spread to the bones which is good.

- CT scans of your tummy and chest were done for the same reason. No metastases means that there is no spread of the cancer to any other part of your body.

*In summary* :

you have a urinary tract infection and cancer of the prostate that has not spread and does not block the outflow of urine. The only concerning part is the Gleeson Score.

## Management

So let me tell you what we can do for you.
Management options are as follows.

- Treat UTI: with antibiotics, eg. trimethoprim 300mg OD for 10-14 days

- Refer to specialist: MDT, urologist, oncologists, GP, cancer nurse. The specialists will discuss and decide with you the treatment option that is most suitable.

- Prostatectomy: Depending on size, most likely a total or radical prostatectomy where entire prostate gland is removed. Surgery is the most likely option in your case.

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- Brachytherapy: Specialist might consider brachytherapy if suitable. This is a form of radiotherapy. Tiny radioactive seeds are directly injected in the tumour to kill any remaining cancer cells.

- ADT: Androgen deprivation therapy is another option if you are suitable. It reduces the production of testosterone so the tumour is less likely to grow.

- Prognosis is good if there is no spread.

- Follow up with regular blood test to check PSA levels

- 4 R's - Reading material, Refer to support groups, Review date
  - Red flags (worsening symptoms or bone pains)



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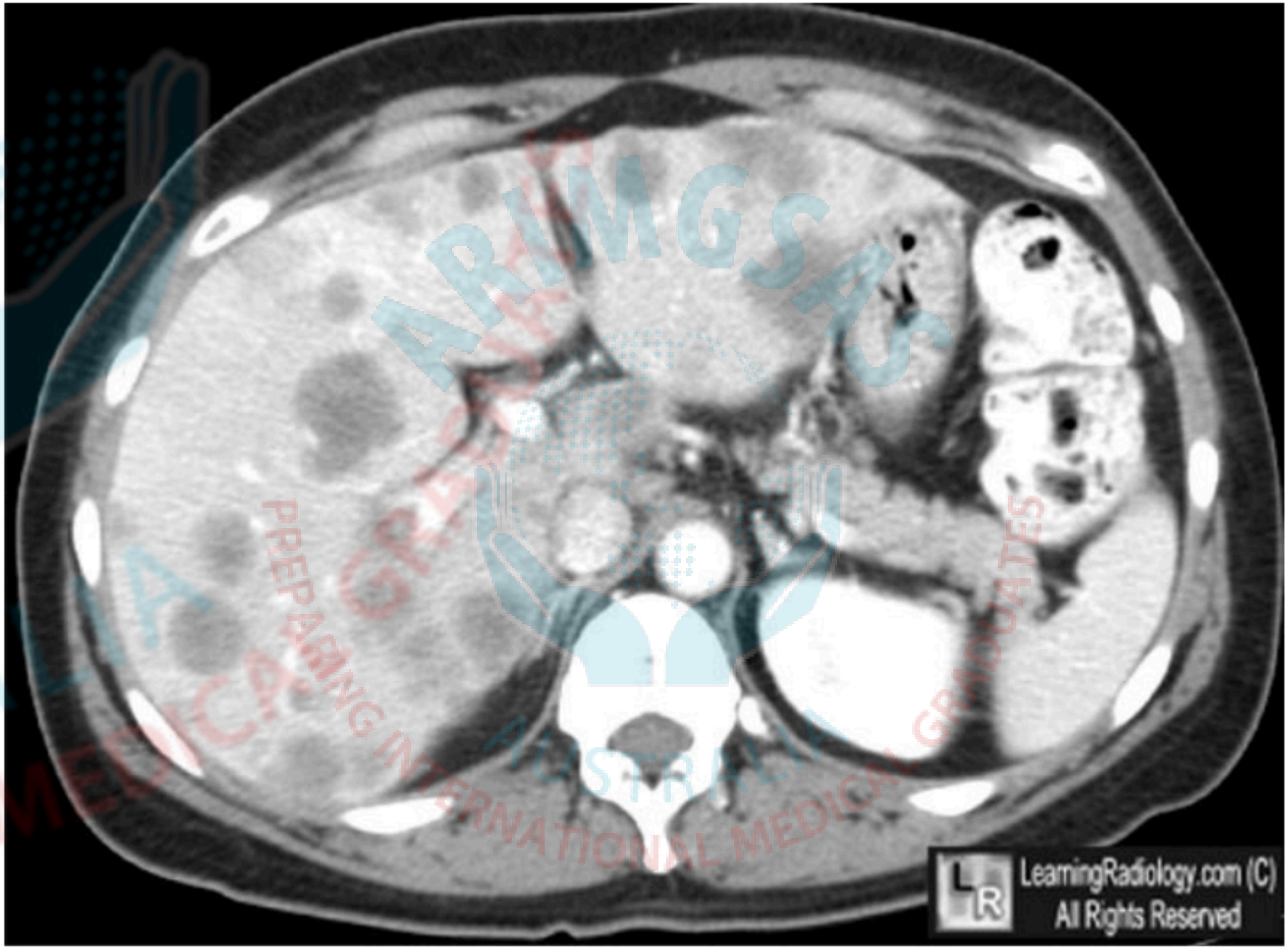
# Case 6

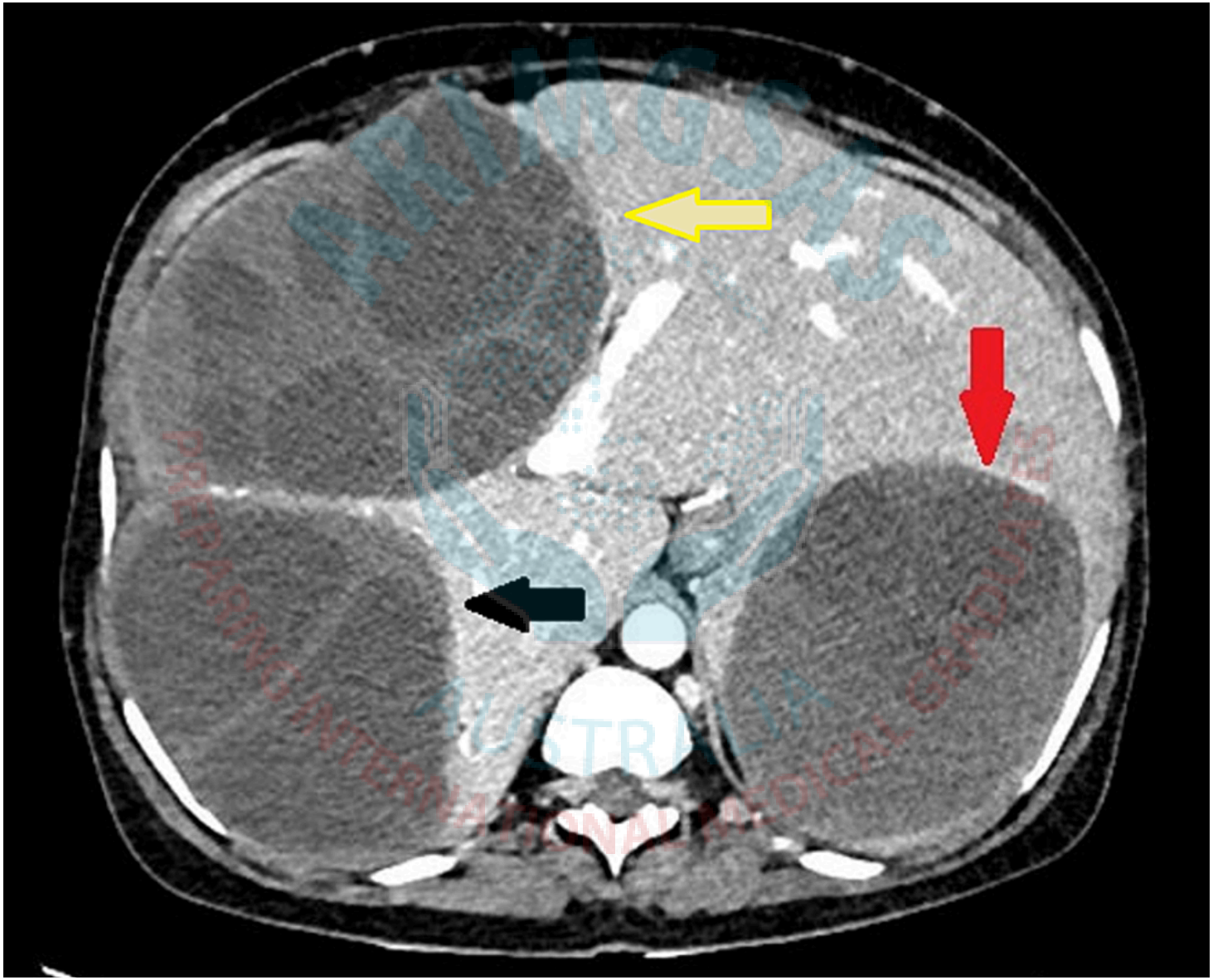
Sheila is one of your patients who is a farmer. Due to abdominal symptoms she was sent for a CT abdomen. Now she comes for results of the scan. Patient has anaemia (microcytic hypochromic), back pain and lower limb swelling. Patient lives on a farm for many years. She has contact with dogs and sheep.

Tasks:

1. Explain the CT scan results
2. Explain the further investigations and management



# To compare: hydatid cysts



## Explanation of CT with SPIKES

**S** - "Thank you for coming back to discuss your results. How are you doing? How is the biopsy site? Is there any pain, bleeding or discharge? Before we go one, I'm going to make sure we are not interrupted, my calls are diverted and my mobile is turned off."

**P** - "Do you have any specific perceptions, concerns or expectations or about the results?"

**I** - "Are you ok for me to go through the results with you now?"
"Are you alone? Do you want me to call someone to be with you?"

**K** - This is a CT scan of your abdomen
Black represents air
White represents bone
Grey represents tissue
You are looking at your liver which is at the upper part of your abdomen.
You are looking at cross section through the liver from below.
This is your L & R side, this is your front, and this is your back (point with finger to orientate)

The CT scan shows that your liver is larger than usual and it has several dark lesions with demarcated margins. I'm sorry to tell you that this looks likely to be metastases.

What this means is that most likely there is cancer elsewhere in your body and it has spread to your liver.

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**E** - PAUSE. SILENCE. “Are you alright?”
Do you want me to continue my explanation?
(Offer water and tissues)
Do you want me to call any member of your family to be with you now?
Do you want me to postpone this session?

## **S** trategies (Management plan)

- Let me tell you what strategies we can follow. We will have to do further investigations to find out exactly what your liver problem is and where the metastases came from. This could be for example from the large intestines, stomach, breast or airways of the lung.

- Oncologist: I will refer you to the oncologist for this

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***Oncology Care***

- Investigations: They will do investigations like blood tests including looking at your liver function and tumour markers.

- Biopsy: They will also take biopsies, or small parts of the liver under CT guidance to investigate the cells under the microscope.

- Scans: Most likely they will also do a scan of your chest (CT chest) and of your rest of your abdomen (if not already done) and pelvis. They will also do scan the breast by mammography. These scans are to find the source of cancer.

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- Endoscopy: They might also consider arranging gastroscopy and colonoscopy, which means that they will pass flexible tubes with cameras through your mouth to look inside the stomach and through the back passage to see the intestines. Again this is to find the source of the cancer.

- Tumour markers: I mentioned earlier, are specific proteins that can be raised in the blood in certain conditions.
  We look at these for two reasons. 1) to check your response to treatment and 2) to assess the prognosis of your condition.

- These tumour markers include:
  - CEA - related to colorectal cancer
  - Ca 19.9 - related to pancreatic cancer (also some GIT cancer)
  - AFP - related to liver cancer
  - (PSA if patient is male)



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***Palliative Care***

- Palliative care specialist: I will also refer you to the palliative care specialist for any possible treatment and pain management.

- MDT: This will be a multidisciplinary approach with the oncologist, palliative care specialist, cancer nurse, GP.

- Palliative care:
  - Let me explain more about it.
  - When, for example cancer, has spread to the liver, lung or lining of the abdomen and pelvis, this is known as advanced or metastatic (stage 4) cancer.
  - The palliative care team will help patients with advanced illness to enjoy life as much as illness will let them.
  - Palliative care can be given at home, nursing home or hospice care centre.

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- Palliative treatment:
  - Sometimes treatments such as surgery, chemotherapy, radiation therapy or targeted therapy are given palliatively. The aim is to help relieve symptoms such as pain or bleeding by shrinking or slowing the growth of the cancer.
  - Palliative treatment helps to improve people's quality of life by managing the symptoms of cancer without trying to cure the disease.
  - It is best thought of as supportive care.

- Multi-aspect:
  - Many people think that palliative treatment is for people at the end of their life, but it may help at any stage of advanced cancer. It is about living for as long as possible in the most satisfying way you can.
  - Palliative treatment is only one aspect of palliative care. In palliative care, there is a team of health professionals aiming to meet your physical, emotional, practical, social and spiritual needs.

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***In your case***

- Most likely the treatment you will receive is chemotherapy and radiotherapy.

- The two aims are to improve your condition and offer palliative care.

- Another treatment is ligation of hepatic artery. This could help to reduce the size of the tumour. But when the lesion is throughout the liver, this treatment option is not suitable.

- If the lesion is only in one lobe of the liver, we can take only that lobe out. But when the lesion is throughout the liver, unfortunately we cannot resect it.



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## At the end…

*Patient asks*:

Am I dying, Dr?

*Answer*:

Please do not lose hope in medicine or science.
There is always hope with new research.
We might not be able to add days to your life
……..BUT we definitely can try to add life to your days.

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# Case 7

You are a GP and your are about to see 58 year old Susan who had a lump in her left breast. She was seen by another GP who had ordered a core biopsy and the biopsy result has shown invasive ductal carcinoma with progesterone and estrogen receptor positive. The lump was 1cm in size and she has come to collect the result of the core biopsy.

Tasks

1. Explain the results to her
2. Explain your further management to the patient

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## Explanation of biopsy with SPIKES

**S** - "How are you doing? how is the biopsy site? Is there any pain, discharge or bleeding?"
"Thank you for coming back to discuss your results. Before we do that, I'm going to make sure we are not interrupted, my calls are diverted and my mobile is turned off."

**P** - "Do you have any perceptions, concerns or expectations about the results?"

**I** - "Are you ok for me to go through the results with you now?"
"Are you alone? Do you want me to call someone to be with you?"

**K** - "I'm sorry to say I do not have good news for you today. The results are back and show that you have breast cancer."

**E** - PAUSE. SILENCE. "Are you alright?"
Do you want me to continue my explanation?
(Offer water and tissues)
Do you want me to call any member of your family to be with you now?
Do you want me to postpone this session?

**S trategies (Management plan)**

- Let me explain what your condition exactly is and what strategies and management plan we can carry out.

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- Type: - The type of breast cancer that you have is invasive ductal carcinoma.
  - This means that the cancer started in the milk tubes and spread into the adjacent breast tissue.
  - This is the most common type of breast cancer.

- Size: - If the size is > 5cm, it is locally advanced.
  - Yours is 1 cm size which has a better outcome.

- Receptor subtype:
  - About two-thirds of breast cancers are hormone receptor positive.
  - Yours is estrogen and progesterone receptor positive.
  - This means that the cancer cells need the female hormones, estrogen and progesterone, to grow and multiply.
  - For this type, special oral medication which is a kind of hormonal therapy, must be taken in addition to other treatments.

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- Specialist:
  I will be referring you to see the breast surgeon and the oncologist.

- MDT:
  There will be a multi-disciplinary team to look after you,
  which includes surgeon, oncologist, cancer nurse, and myself the GP.

- Staging:
  - If there is suspicion of spread to other parts of the body, the specialist will order further tests.
  - This includes CT of liver, lungs, brain and bone scan.
  - Blood tests like FBE, PBF, LFT, Ca may also be done.



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- Treatment:
  - There are a number of treatments available.
  - These will depend on the results of further tests.
  - The most suitable treatment options will be discussed with you by the specialists.

- Options: include surgical and non-surgical treatments.

  *Surgical options*:
  - surgery to remove the lump (lumpectomy) or breast (mastectomy).
  - At the time of surgery if it is discovered through lymph node biopsy that the lymph nodes in the arm pit are involved, then these lymph nodes will be removed.
  - Breast reconstruction can also be carried out if it is suitable for you.

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*Non-surgical options*:

- include chemotherapy and radiotherapy
- and also in your case hormonal therapy since your biopsy showed positive estrogen and progesterone receptors.
- Medications that block these receptors will need to be taken daily for 5 years and will reduce the chances of the cancer returning.

- I will also arrange
  - Family meeting
  - Reading material for you
  - Referral to psychologist or counsellor if unable to cope
  - Referral to support group

- *"Let me REASSURE you that I am here to support you throughout this process of investigations and treatment."*
- *"If you have any questions, please come and ask me at any time."*

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ARIMGSAS
PREPARING INTERNATIONAL MEDICAL GRADUATES
AUSTRALIA

Resources

1. Cancer Council Australia - https://www.cancer.org.au
2. Better Health Channel - https://www.betterhealth.vic.gov.au
3. Mayo Clinic - https://www.mayoclinic.org/diseases-conditions


Thank You!

And wishing you all the best!

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