

Five Things Physicians and Patients Should Question

1

Don't routinely use sentinel node biopsy in clinically node negative women ≥ 70 years of age with early stage hormone receptor positive, HER2 negative invasive breast cancer.

Hormonal therapy is standard for all patients with hormone receptor positive disease. The omission of sentinel lymph node biopsy in clinically node negative women ≥ 70 years of age treated with hormonal therapy does not result in increased rates of locoregional recurrence and does not impact breast cancer mortality. Patients ≥ 70 years of age with early stage hormone receptor positive, HER2 negative breast cancer and no palpable axillary lymph nodes can be safely treated without axillary staging. Axillary staging can be individually considered, if the results may impact systemic therapy decisions.

2

Don't routinely use breast MRI for breast cancer screening in average risk women.

MRI screening should be reserved for those at increased risk. Women considered at high risk include: known BRCA gene mutation carriers; untested first-degree relatives of known BRCA gene mutation carriers; those with a lifetime risk exceeding 20% as measured by risk-assessment tools based primarily on family history of breast cancer; and those with a clinical history associated with a significant risk for breast cancer, including women who received mantle radiation before the age of 30. MRI for screening after treatment for breast cancer is not indicated in women who would otherwise be considered average risk.

3

Don't obtain routine blood work (e.g., CBC, liver function tests) other than a CEA level for surveillance for colorectal cancer.

Due to lack of sensitivity and accuracy in detecting early recurrences, current evidence does not support measurement of CBC or liver function tests for surveillance following colorectal cancer treatment. Although evidence is not unequivocal, surveillance regimens that include serial carcinoembryonic antigen (CEA) testing have been associated with improved survival.

Depending on the stage of non-metastatic disease, accepted components for colorectal cancer surveillance include a combination of history and physical examination; CEA; CT of the chest, abdomen and pelvis; and colonoscopy at variable intervals depending on stage and risk of recurrent disease.

4

Don't perform routine PET-CT in the initial staging of localized colon or rectal cancer or as part of routine surveillance for patients who have been curatively treated for colon or rectal cancer.

A CT of the chest, abdomen and pelvis with IV and PO contrast provides excellent staging and standard PET imaging does not significantly improve diagnostic accuracy or outcomes as part of the initial workup or surveillance testing. Use of PET does not eliminate the need for recommended staging CT but does increase costs.

5

Don't routinely order imaging studies for initial staging purposes prior to surgery on a patient with clinically localized primary cutaneous melanoma unless there is suspicion for metastatic disease based on history and/or physical exam.

Routine imaging studies for localized melanoma including chest radiographs, brain MRI, cross-sectional imaging and PET/CT are insensitive at the lower limits of resolution and do not significantly improve staging of these patients. There is a low risk of metastases and also a risk of detecting findings unrelated to the melanoma (e.g., false positive findings or incidental, unrelated findings). Imaging should be performed if there are concerning findings on history and physical exam, and such tests should be driven by symptoms.

How This List Was Created

The Society of Surgical Oncology (SSO) maintains disease site workgroups (DSWGs) to represent the various disease sites associated with surgical oncology. The DSWGs are comprised of experts in the following disease sites: gastrointestinal, melanoma/sarcoma, breast, hepatobiliary, endocrine/head & neck, colorectal and peritoneal surface malignancy. The SSO Quality Committee initiated the *Choosing Wisely* measure development process by asking the DSWGs to identify tests or procedures commonly used in their respective areas of expertise whose necessity should be questioned and discussed. The Quality Committee received submissions from six disease sites; however, because the list was limited to five measures, the Committee felt it was precluded from incorporating measures representing all disease sites. As a means of refining the list of *Choosing Wisely* measures, the Quality Committee elected to include the five measures impacting the largest number of patients. The draft list was reduced significantly – eliminating the gastrointestinal, endocrine, hepatobiliary, sarcoma and peritoneal surface malignancies measures. The five measures were selected from the breast, colorectal and melanoma sets. These five measures were submitted to and approved by the SSO Executive Council.

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Sources

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About the Society of Surgical Oncology

The Society of Surgical Oncology (SSO) is a dynamic global community of cancer surgeons shaping advancements in the profession to deliver the highest quality surgical care for cancer patients. SSO promotes leading-edge research, quality standards and knowledge exchange connecting cancer surgeons worldwide to continuously improve cancer outcomes. Our highly regarded educational events and resources inspire members and spur each cancer surgeon to grow, improve and thrive. SSO's focus on all solid-tumor diseases sites is reflected in its Annual Cancer Symposium and scientific journal, *Annals of Surgical Oncology*. The Society's membership is representative of nearly 70 countries and outreach efforts include partnerships with nine global societies. In addition, the SSO has organized the Global Forum of Cancer Surgeons, a group of 12 international societies with the goal of addressing the lack of adequate surgical care for cancer patients.



For more information, visit www.surgonc.org.

For more information or to see other lists of Things Clinicians and Patients Should Question, visit www.choosingwisely.org.