

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.

Endocrine therapy is standard treatment for all patients with hormone receptor positive breast cancer. The omission of sentinel lymph node biopsy in patients with non-palpable axillary lymph nodes in those women ≥ 70 years of age treated with endocrine 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 radiation therapy recommendations and/or 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 of developing breast cancer. Women considered at high risk include: known BRCA gene mutation carriers; untested first-degree relatives of known BRCA gene mutation carriers; those with moderate penetrance gene mutations including CHEK2, PALB2, ATM, PTEN, CDH1 and p53; 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 following standard radical resection 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

- Hughes KS, Schnaper LA, Bellon JR, Cirrincione CT, Berry DA, McCormick B, Muss HB, Smith BL, Hudis CA, Winer EP, Wood WC. Lumpectomy plus tamoxifen with or without irradiation in women age 70 years or older with early breast cancer: long-term follow-up of CALGB 9343. *J Clin Oncol* 2013 Jul 1;31(19):2382-7.
Martelli G, Miceli R, Daidone MG, Vetrella G, Cerrotta AM, Piromalli D, Agresti R. Axillary dissection versus no axillary dissection in elderly patients with breast cancer and no palpable axillary nodes: results after 15 years of follow-up. *Ann Surg Oncol*. 2011 Jan;18(1):125–33.
Rudenstam CM, Zahrieh D, Forbes JF, et al., International Breast Cancer Study Group. Randomized trial comparing axillary clearance versus no axillary clearance in older patients with breast cancer: first results of International Breast Cancer Study Group Trial 10-93. *J Clin Oncol* 2006;24(3):337e44.
Chung A, Gangi A, Amersi F, Zhang X, Giuliano A. Not performing a sentinel node biopsy for older patients with early-stage invasive breast cancer. *JAMA Surg* 2015 Jul 1;150(7):683e4. <https://doi.org/10.1001/jamasurg.2015.0647>.
- Saslow D, Boetes C, Burke W, Harms S, Leach MO, Lehman CD, Morris E, Pisano E, Schnall M, Sener S, Smith RA, Warner E, Yaffe M, Andrews KS, Russell CA; American Cancer Society Breast Cancer Advisory Group. American Cancer Society guidelines for breast screening with MRI as an adjunct to mammography. *CA Cancer J Clin*. 2007 Mar-Apr;57(2):75-89. Erratum in: *CA Cancer J Clin*. 2007 May-Jun;57(3):185.
Mulder RL, Kremer LC, Hudson MM, Bhatia S, Landier W, Levitt G, Constine LS, Wallace WH, van Leeuwen FE, Ronckers CM, Henderson TO, Dwyer M, Skinner R, Oeffinger KC; International Late Effects of Childhood Cancer Guideline Harmonization Group. Recommendations for breast cancer surveillance for female survivors of childhood, adolescent, and young adult cancer given chest radiation: a report from the International Late Effects of Childhood Cancer Guideline Harmonization Group. *Lancet Oncol*. 2013 Dec;14(13):e621-9.
- National Comprehensive Cancer Network. Colon Cancer. Version 2.2021. Clinical Practice Guidelines in Oncology [Internet]. March 2, 2021. Accessed: June 21, 2021. https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf.
Benson AB, Venook AP, Al-Hawary MM, Arain MA, Chen YJ, Ciombor KK, Cohen S, Cooper HS, Deming D, Farkas L, Garrido-Laguna I, Grem JL, Gunn A, Hecht JR, Hoffe S, Hubbard J, Hunt S, Johung KL, Kirilcuk N, Krishnamurthi S, Messersmith WA, Meyerhardt J, Miller ED, Mulcahy MF, Nurkin S, Overman MJ, Parikh A, Patel H, Pedersen K, Saltz L, Schneider C, Shibata D, Skibber JM, Sofocleous CT, Stoffel EM, Stotsky-Himelfarb E, Willett CG, Gregory KM, Gurski LA. Colon Cancer. Version 2.2021. NCCN Clinical Practice Guidelines in Oncology. *J Natl Compr Canc Netw*. 2021 Mar 2;19(3):329-359.
El-Shami K, Oeffinger KC, Erb NL, Willis A, Bretsch JK, Pratt-Chapman ML, Cannady RS, Wong SL, Rose J, Barbour AL, Stein KD, Sharpe KB, Brooks DD, Cowens-Alvarado RL. American Cancer Society colorectal cancer survivorship care guidelines. *CA Cancer J Clin*. 2015;65(6):428-55.
Meyerhardt JA, Mangu PB, Flynn PJ, Korde L, Loprinzi CL, Minsky BD, Petrelli NJ, Ryan K, Schrag DH, Wong SL, Benson AB 3rd; American Society of Clinical Oncology. Follow-up care, surveillance protocol, and secondary prevention measures for survivors of colorectal cancer: American Society of Clinical Oncology clinical practice guideline endorsement. *J Clin Oncol*. 2013 Dec 10;31(35):4465-70.
- National Comprehensive Cancer Network. Colon Cancer. Version 2.2021. Clinical Practice Guidelines in Oncology [Internet]. March 2, 2021. Accessed: June 21, 2021. https://www.nccn.org/professionals/physician_gls/pdf/colon.pdf.
Benson AB, Venook AP, Al-Hawary MM, Arain MA, Chen YJ, Ciombor KK, Cohen S, Cooper HS, Deming D, Farkas L, Garrido-Laguna I, Grem JL, Gunn A, Hecht JR, Hoffe S, Hubbard J, Hunt S, Johung KL, Kirilcuk N, Krishnamurthi S, Messersmith WA, Meyerhardt J, Miller ED, Mulcahy MF, Nurkin S, Overman MJ, Parikh A, Patel H, Pedersen K, Saltz L, Schneider C, Shibata D, Skibber JM, Sofocleous CT, Stoffel EM, Stotsky-Himelfarb E, Willett CG, Gregory KM, Gurski LA. Colon Cancer. Version 2.2021. NCCN Clinical Practice Guidelines in Oncology. *J Natl Compr Canc Netw*. 2021 Mar 2;19(3):329-359.
Balthazar EJ, Megibow AJ, Hulnick D, Naidich DP. Carcinoma of the colon: detection and preoperative staging by CT. *AJR Am J Roentgenol*. 1988 Feb;150(2):301-6.
Cipe G, Ergul N, Hasbahceci M, Firat D, Bozkurt S, Memmi N, Karatepe O, Muslumanoglu M. Routine use of positron-emission tomography/computed tomography for staging of primary colorectal cancer: does it affect clinical management? *World J Surg Oncol*. 2013 Feb 27;11:49.
- Wang TS, Johnson TM, Cascade PN, Redman BG, Sondak VK, Schwartz JL. Evaluation of staging chest radiographs and serum lactate dehydrogenase for localized melanoma. *J Am Acad Dermatol* 2004 Sep;51:399-405.
Mohr P, Eggermont AM, Hauschild A, Buzaid A. Staging of cutaneous melanoma. *Ann Oncol*. 2009 Aug;20 Suppl 6:vi14-21.

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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.



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