

### Five Things Physicians and Patients Should Question

#### 1 Don't routinely use sentinel node biopsy in clinically node negative women $\geq 70$ years of age with hormone receptor positive 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  $\geq 70$  years of age treated with hormonal therapy does not result in increased rates of locoregional recurrence and does not impact breast cancer mortality. Patients  $\geq 70$  years of age with early stage hormone receptor positive breast cancer and no palpable axillary lymph nodes can be safely treated without axillary staging.

#### 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; 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.

#### 3 Don't obtain routine blood work (e.g., CBC, liver function tests) other than a CEA level during 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 with IV and PO contrast but does increase costs.

#### 5 Don't routinely order imaging studies for staging purposes on patients newly diagnosed with localized primary cutaneous melanoma unless there is suspicion for metastatic disease based on history and 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 and colorectal. 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 all 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 endocrine, hepatobiliary, and sarcoma 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

Founded in 1940 as the James Ewing Society, the Society of Surgical Oncology® is the preeminent organization for surgeons, scientists and health care specialists dedicated to advancing the treatment of cancer through leading edge scientific research and surgical techniques.



The Society's 2,800 U.S. and international members are at the forefront of the field, representing premier universities, hospitals and cancer centers from around the globe; in addition to its domestic initiatives, the Society has entered into agreements with six international surgical societies to advance collaborative cancer care education globally. The Society's focus on all solid-tumor disease sites is reflected in its Annual Cancer Symposium, monthly scientific journal (*Annals of Surgical Oncology*), education initiatives and committee structure. The mission of the Society of Surgical Oncology is to improve multidisciplinary patient care by advancing the science, education and practice of cancer surgery worldwide.

For more information, visit [www.surgonc.org](http://www.surgonc.org).

For more information or to see other lists of Things Clinicians and Patients Should Question, visit [www.choosingwisely.org](http://www.choosingwisely.org).