**Greater Manchester Breast Services**

**Risk-Reducing Endocrine Medication Prescription Request to Primary Care**

**RALOXIFENE**

Use this document to inform the patient and the GP of the patient’s treatment plan with regard to risk-reducing endocrine medication.

Use the **Greater Manchester Breast Cancer Risk Assessment Document** and the **Greater Manchester Risk-Reducing Endocrine Guidelines and Management Algorithms** to ensure that your patient is eligible for risk-reducing endocrine therapy and that they do not have any contraindications to starting this medication: <https://gmcancer.org.uk/cancer-pathway-boards/breast/endocrine-therapy/>

Please delete this guidance box and remember to ensure sections don’t overrun onto the next page and titles don’t separate from the body of the text before sending.

Remove all wording that does not apply to a particular patient in order to personalise it to the individual.

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| **Patient Name** |  |
| **Date of Birth** |  |
| **Hospital Number** |  |
| **NHS Number** |  |

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| **ACTION FOR GP** | |
| Your patient has been assessed in the breast family history clinic by a specialist nurse or doctor and, as per NICE guidelines, has been found to be eligible for risk-reducing endocrine therapy to reduce her risk of developing breast cancer in the future. | |
| **Prescription medication:** | **We have commenced treatment with Raloxifene.**  **Please continue Raloxifene 60mg tablet once daily for 5 years.**  The Greater Manchester Medicines Management Group, has determined that risk-reducing Raloxifene is on the GREEN LIST(primary care prescribing, after specialist initiation) |
| **Follow up Plan:** | Your patient will be followed up in **3 MONTHS** by the family history team to ensure they are tolerating the medication. Your patient has been advised that they can contact us directly in this time if they have any concerns. |
| If your patient experiences menopausal symptoms, as a side effect of the risk-reducing endocrine treatment, please see the additional information section of this document for further advice about managing these symptoms. | |

Dear ***[INSERT PATIENT NAME]***

Thank you for attending your appointment to discuss reducing your future risk of developing breast cancer.

You have expressed today that you would like to start endocrine (hormone) medication to reduce this risk. Please find, in this letter, a summary of your breast cancer risk assessment, the endocrine medication we discussed and its side effects. A copy of this letter has also been sent to your GP who will be able to regularly prescribe this medication for you.

If you would like further advice about your breast cancer risk, risk-reducing endocrine medication, or anything else we have discussed in clinic, please contact the Family History Service on the number below. This number may take you to a voicemail, where you should leave a message with your name, date of birth and telephone number and a member of our team will get back you as soon as possible.

Kind Regards, The Family History Team

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| **Key Contact Number:** | ***[INSERT TELEPHONE NUMBER]*** |

**Breast Cancer Risk Assessment:**

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| **Results** | **Ten-year risk: 1 in ……(….%) risk of breast cancer**  **Lifetime risk: 1 in …… (….%) risk of breast cancer** |
| **What does your result mean?**  Your family history and personal history means that you have  *[DELETE AS APPROPRIATE]*  a moderately increased risk of developing breast cancer in the future compared to the general population.  a high risk of developing breast cancer in the future compared to the general population.  Being at increased risk does not mean that you will definitely develop breast cancer, but it does mean that you have a greater risk than the general population.  By choosing to take risk-reducing endocrine medication, you are taking medically-approved action to reduce this risk. | |

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| **Assessment of contraindications:** | I have confirmed that the patient is over 35 years and under 70 years of age.  I have confirmed that the patient does not have any of the following:   * Personal history of DVT or PE * A first degree relative with history of DVT/PE, without precipitating factors * A BMI greater or equal to 35 * Significant limitations to her mobility * Significant cardiac or respiratory co-morbidity   I have confirmed that the patient is not pregnant, and is not planning to conceive, whilst taking this medication. |
| **Document completed by:** | **Name:**  **Position:**  **Date:** |
| Copy sent to GP: | **Yes/No** *[Delete as appropriate]* |
| Copy sent to other Health Care Professional(s): | **Yes/No** *[Delete as appropriate]*  *[Insert details]* |

**Additional information for the GP**

We have assessed your patient for contraindications and drug interactions and, from the information they have provided, we can recommend that it is safe to prescribe this medication. A list of contraindications and interactions is listed below and so, if you note an area of concern that your patient has not advised us of, please can you contact us on the number provided above and do not prescribe the medication.

**Your patient has been advised that it may take time for this letter to be sent, received and actioned by your practice and so they should contact your surgery in 4 weeks’ time to request that you issue this medication.**

**Managing side effects of all risk-reducing endocrine medication**

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| *Please find below information about managing the possible side-effects of risk-reducing medication.*  *If further information is required, please ask the patient to contact the family history clinic directly.* | |
| **Nausea:** | Advise to take with food or milk. Usually settles within a few weeks |
| **Hormonal effects**:  Hot flushes  Night sweats  Vaginal dryness/discomfort  Decreased libido (sex drive)  Mood swings or low mood | These side effects are common and may settle within a few months.  If menopausal symptoms persist, first treat with conservative measures:   * Cooling measures: loose clothing, well-ventilated rooms, taking a cool shower before bed, light bed sheets, use of a cooling pillow to aid sleep * Cut down on caffeine, alcohol and spicy food, and stop smoking, as they can all trigger hot flushes * Regular exercise can reduce hot flushes and improve sleep   If conservative measures do not adequately control menopausal symptoms, you may wish to consider one of the following medications:   * Venlafaxine MR 75mg daily increasing to 150mg daily if required * Oxybutinin 2.5mg twice daily (bd) increasing to 5mg twice daily (bd) if required   **Vaginal dryness** should initially be managed with vaginal moisturisers that do not contain oestrogen e.g. *ReplensMD* or *YesVM.* These should be used regularly, not just for sexual intercourse.  If symptoms persist, despite vaginal moisturisers, a vaginal lubricant containing a low dose of oestrogen (0.005% oestriol vaginal gel e.g. Blissel 50ug/g) is acceptable.  **Please do not prescribe HRT whilst the patient is taking risk-reducing medication, as this will counteract the beneficial effects of risk-reducing endocrine treatment.** |

**Contraindications/ Cautions/ Drug Interactions of Raloxifene**

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| **Contraindications:** | Not recommended for women under 35 years of age.  History of previous allergic reaction**,** personal history of DVT/PE**,** family history of first degree relative with DVT/PE under 45 years without precipitating factors, cholestasis. |
| **Cautions:** | Pregnancy and breast feeding. Raloxifene should be stopped 3 months before trying to conceive.  Due to the increased risk of venous thromboembolism, Raloxifene should be discontinued 6 weeks prior to elective surgery.  If there is a history of oestrogen-induced hypertriglyceridemia monitor serum triglycerides and use with caution if the patient has risk factors for stroke. Avoid in acute porphyria. |
| **Monitoring:** | There is no routine monitoring necessary for patients on Raloxifene. |