

Survivorship Follow-Up Care for Primary Care Providers



Primary care providers play a pivotal role in the clinical follow-up care of cancer survivors.

It's important to understand how best to treat patients after they've finished cancer treatment, as it poses unique challenges depending on the type and stage of cancer, as well as the treatment received.

Possible Long-Term or Late Effects of Cancer Treatment

SURGERY: Numbness, weakness, pain, loss of range of motion, poor cosmetic outcome, lymphedema, and sexual dysfunction.

CHEMOTHERAPY: Fatigue, neuropathy, cognitive dysfunction, sexual dysfunction, increased risk of cardiovascular disease, osteoporosis/osteopenia, risk of secondary cancers such as leukemia/myeloproliferative disorders with alkylating agents, anthracyclines, and other agents with immunosuppressive potential.

RADIATION: Fatigue; pain in the area of radiation; lymphedema; injury to the ribs, bone, lungs, heart, brachial plexus, and/or lymph nodes; fibrosis; atrophy; poor cosmetic outcome; and secondary cancers in treated fields.

HORMONE THERAPIES:

- **TAMOXIFEN:** Hot flashes, sexual dysfunction, increased risk of blood clots, uterine cancer, and stroke.
- **AROMATASE INHIBITORS:** Bone thinning, myalgias, arthralgias, hot flashes, and sexual dysfunction.

CARDIAC RISK RELATED TO ANTHRACYCLINES:

Anthracycline chemotherapies may cause cardiac toxicities such as cardiomyopathy, arrhythmias, and heart failure. The risk is higher if other cancer therapies with cardiac side effects are given, such as cardiotoxic and chest/mediastinal radiation therapy.

Pain Management

Patients may experience persistent pain resulting from their cancer treatment. If the pain is progressive and/or persistent, please refer them to their oncologist for help with pain management.

Cancer survivors should continue to be screened for recurrence, as well as for distress and psychosocial health needs.

Symptom of Recurrence

ALL CANCERS: Acute unintentional weight loss and/or progressive fatigue

BONE: Persistent bone pain, fracture

BRAIN: New, focal headache, visual changes, balance problems, memory decline, confusion, trouble with speech, one-sided weakness seizure, right posterior shoulder pain

BREAST: Mass in breast or nodules in skin if mastectomy, skin wrinkling or rash, nipple inversion or discharge, breast pain

LIVER: Right upper abdominal pain, yellowing of the skin, easy bleeding or bruising, elevated liver enzymes

LUNG: New, persistent dry cough, shortness of breath with exertion, wheezing

Ongoing General Screening and Health Guidelines

YEARLY PHYSICAL EXAM: Patients should follow up with their primary care provider at least once a year for a complete physical exam, including cholesterol, diabetes, and thyroid function monitoring.

COLONOSCOPY: Colon cancer screening begins at age 45 and is done every 10 years, unless patient is at high risk – then it may be done sooner and at closer intervals.

IMMUNIZATIONS: Patients should get yearly influenza and other recommended immunizations.

ANNUAL MAMMOGRAPHY: Breast cancer screening begins at age 40. Women who are at high risk for breast cancer should get a breast MRI and a mammogram annually, typically starting 10 years prior to the earliest breast cancer diagnosis in the family.

BONE HEALTH: Postmenopausal women should receive a bone density scan every two years or as directed.

CERVICAL CANCER SCREENING: For women ages 21-24, no screening is needed. Women ages 25-65 should have an HPV test every five years. If HPV testing is not available, women can get screened with an HPV/PAP co-test every five years, or a PAP test every three years. Women ages 65 and older don't need screening if a series of prior tests were normal.

PROSTATE CANCER SCREENING: For men at average risk, begin discussion about the benefits and risks of prostate cancer screening at age 50.

LUNG CANCER SCREENING: Those at high risk should undergo an annual low-dose chest CT, starting at age 50.

Recommended Patient Follow-Up Schedule¹

TREATMENT SITE	YEARS 1-2	YEARS 3-5	YEAR 5 AND BEYOND
BREAST	<ul style="list-style-type: none"> History and physical exam every 3-6 months Annual mammography for intact breast 	<ul style="list-style-type: none"> Physical every 6-12 months for the next 2 years 	Annual physical
PROSTATE	<ul style="list-style-type: none"> Measure PSA level every 6-12 months Annual DRE in coordination with specialist to avoid duplication 	<ul style="list-style-type: none"> Measure PSA level 6-12 months If PSA rises, refer back to oncologist 	Measure PSA level annually
COLORECTAL	<ul style="list-style-type: none"> History and physical every 3-6 months CEA testing every 3-6 months If advanced adenoma, annual colonoscopy 	<ul style="list-style-type: none"> Physical every 6 months CEA testing every 6 months Year 4: If no adenoma, colonoscopy every 5 years 	Colonoscopy every 5 years, starting 9 years after resection
HEAD AND NECK	<ul style="list-style-type: none"> Year 1: History and physical every 3-6 months Year 2: History and physical every 2-6 months 	<ul style="list-style-type: none"> Physical every 4-8 months 	Annual physical
GYNECOLOGICAL	<ul style="list-style-type: none"> History and physical every 4-5 months 	<ul style="list-style-type: none"> Physical every 6 months 	Annual physical if co-managed with gynecologist

¹ GW Cancer Institute & American Cancer Society