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We must remove access barriers to endocrine drugs for breast cancer prevention

Anastrozole and other risk-reducing endocrine drugs are promising preventive treatments for breast cancer, but barriers to access remain, writes Nicola Weaver

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It was a welcome surprise to see anastrozole in the national headlines recently.[1] The Medicines and Healthcare products Regulatory Agency in the UK has granted a licence for its use[2] as a preventive medicine in women who are post-menopause and at higher risk of breast cancer—this is in addition to the already licensed drug tamoxifen which is available for the same purposes to women who are pre-menopause. Anastrozole and other risk-reducing endocrine drugs are promising preventive treatments, but substantial barriers to access must be overcome to ensure eligible women can benefit.

The addition of anastrozole is positive news because it is a drug that provides the same, or even better, outcomes in breast cancer prevention than tamoxifen, but with a different side effect profile, making it potentially safer than tamoxifen for use in women who are post-menopause.

In 2021 I acted as GP clinical champion to the NHS England "Rapid Uptake Products" project which aimed to increase the use of tamoxifen—and anastrozole pending a licence—in the primary prevention of breast cancer. Research shows that in women who are at increased risk, five years' treatment can significantly reduce the incidence of breast cancer, with benefits lasting years after treatment.[3] Unfortunately, several obstacles hindered progress, including identifying women at increased risk of breast cancer and problems with NHS prescribing pathways. These factors resulted in the project being terminated prematurely.

In 2022 the National Institute for Health and Care Excellence (NICE) Guidelines Committee agreed to remove the controversial statement in their Familial Breast Cancer Guidelines that healthcare professionals "should not, in most instances, actively seek to identify people with a family history of breast cancer." This had been standing in the way of systematic attempts to identify women who might benefit from preventive treatment. Subsequently some promising initiatives have started, including the use of a digital online assessment tool with women invited from a number of general practice lists.[4]

Structural access barriers still exist in the NHS to the prescribing of anastrozole and tamoxifen for women who may be eligible. Anastrozole and tamoxifen are defined by NICE guidelines as secondary care initiated treatments. However, often no "prescriber" is attached to the family history clinics, where assessment is done by expert nursing staff who can advise on but not initiate the prescription of drugs. This places an unreasonable expectation on GPs, who may be asked to prescribe outside current NICE guidelines without appropriate support.

The Greater Manchester Cancer Alliance is leading pioneering work in developing sufficient shared care support for GPs to initiate prescribing, following advice from specialist nurses. The Greater Manchester Medicines Management Group has now relabelled tamoxifen as an Area Prescribing Committee "green" drug, meaning that it can be initiated by primary or secondary care providers, which is encouraging as a model for us all to follow.

In the past, anastrozole and tamoxifen have been prescribed mostly for women who have received a cancer diagnosis and have undergone a variety of other treatments. In that context, the drugs have a reputation for causing side effects, which is not entirely replicated when they are used in primary prevention. Tamoxifen doubles the risk of deep vein thrombosis to two in 1000 per year, similar to the risk level of the oral contraceptive pill.[3] Uterine carcinoma risk is increased in women post-menopause (without a hysterectomy) who take tamoxifen but not anastrozole. Anastrozole can cause some osteopenia, which may increase the risk of fractures.[5] Flushing occurs in some women but often settles after a few months of treatment. Many women, however, do not experience any significant side effects.

Anastrozole and other preventive drugs can benefit women who, with the right support, can make their own judgment about actions to reduce risk. We should approach this in a way that does not increase inequality,[6] and any action we take needs to make inclusion a priority. Currently, because of lack of awareness and organisational issues, most women who could benefit are still missing the opportunity to make this choice. We need to make it a priority to improve awareness of, and remove the obstacles to, this effective form of breast cancer prevention.

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