Director: Dr Nigel Gray A.M. MB. BS. Hon. LL.D. FRACP. FRACMA

Anti-Cancer Council of Victoria

smac/lr-1

16 May, 1990

Minister for Health
Minister's Office
22nd Floor, 555 Collins Street
Melbourne 3000

Attention: Solange Shapiro

Dear Minister

re: Mammographic Screening and AHMAC

The State Mammographic Screening Advisory Committee has a duty to advise you on the development and coordination of mammographic screening in Victoria.

Hearing that screening would be on the agenda of the meeting of AHMAC on 1st June 1990, and would then be considered by the meeting of Australian Health Ministers, the State Advisory Committee met on 14th May and decided to up-date its advice to you.

No doubt AHMAC will receive recommendations from several sources. One of these will be the Screening Evaluation Coordination Unit (SECU). This unit was set up by the Commonwealth Department of Community Services and Health after the Victorian initiative had been taken to establish a pilot screening program (the RMH-ACCV Breast X-Ray Program) at Essendon. The Essendon program has tried to help SECU in their attempts to pool data from several state pilot projects, but the relationship has been a difficult one. We have been given to understand that, despite the program's best efforts the time-lines set by SECU for recent data provision have been hard to meet. We are unsure of the extent to which SECU's report will take account of the large amount of material sent from the Essendon program, or indeed whether data from other states will have been comprehensively included and taken into account in SECU's formulation of advice.

Against this background of concern about the manner in which SECU will have put together its report to AHMAC, the State Mammographic Screening Advisory Committee considered it important to update its advice to you directly, taking fully into account, among other things, the most recent information from the Essendon program. I enclose the Committee's report to you dated 16 May 1990 which includes a series of recommendations.

We believe you may wish to send a copy of this report to the other members of AHMAC so as to ensure that at their meeting they can take into account the facts and recommendations expressed in it. We would be happy to carry out the task of distribution on your behalf if you can provide us with names and addresses of AHMAC members.

If there are points in our report that you would like to discuss we will be glad to make ourselves available. Also, when the report from SECU is received by your Department, we would be happy to provide comment at very short notice. A telephone call to me or Dorothy Reading at 662.3300 would achieve this.

Yours sincerely

RRH Lovell
Executive Secretary
State Mammographic Screening Advisory Committee

KEOGH HOUSE, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053
☎ (03) 662 3300 Facsimile: (03) 663 3412 Telex: ACCV AA 34158

AUSTRALIAN CANCER SOCIETY MEMBER

Director: Dr Nigel Gray A.M. MB. BS. Hon. LL.D. FRACP, FRACMA

Anti-Cancer Council of Victoria

smac/doc2

STATE MAMMOGRAPHY SCREENING ADVISORY COMMITTEE

REPORT TO THE MINISTER OF HEALTH, VICTORIA

16 MAY 1990

DEVELOPMENT OF MAMMOGRAPHIC SCREENING IN VICTORIA

1. Introduction

1.1 The State Mammography Screening Advisory Committee (SMAC) in Victoria has a duty to advise the Minister of Health on the development of mammographic screening in the State.

1.2 Aware that the Australian Health Ministers' Advisory Council (AHMAC) and then the Australian Health Ministers meeting will shortly be considering the use of federal government funds for mammography, SMAC has reviewed the situation in Victoria.

1.3 In this review account has been taken of the most up-to-date experience of the pilot mammography project - the Royal Melbourne Hospital - Anti-Cancer Council of Victoria Essendon Breast X-ray Screening Program - which has operated since October 1988. Note has also been taken of the Statement released by the Australian Cancer Society on 14 February 1990, endorsing the Statement of the National Breast Study Committee, in which it is said:

> "There is reasonable evidence that mammographic screening in **research settings** can reduce the death rate from breast cancer in women over 50 years of age." [bolding added]

1.4 Experience with the Essendon Breast X-ray Program has been reported to the Screening Evaluation Coordination Unit [SECU]. Some background statistical notes relevant to Victoria are appended. (Attachment)

2. Objectives

2.1 **To ensure that all mammography is good mammography**

2.2 **To develop mammography in this State in the light of present knowledge, including what is being learnt from the RMH-ACCV Essendon Breast X-ray Screening Program.**

3. High quality mammography

3.1 The first objective - high quality mammography - is being met by the requirements of the State Radiation Advisory Committee which is set up by an Act of Parliament in Victoria. The Committee has already set down requirements for registration of equipment for screening mammography and has indicated that for purposes of registration of equipment, the professional guidelines to be followed will be those of the Royal Australasian College of Radiologists.

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AUSTRALIAN CANCER SOCIETY MEMBER

4. Development of screening mammography

4.1 The possible effectiveness of screening mammography depends not only on a high proportion of the population at risk being regularly screened at a high level of technical excellence, but also on excellence in the assessment and management of women found to have x-ray abnormalities. Mammographic screening is not an end in itself.

4.2 Excellence in assessment and in management means using highly specialised skills in diagnostic biopsy procedures, and in analysis of the pathology in tissue specimens, to avoid diagnostic errors. It also means making critical decisions on the treatment that is optimal: for example the use of conservative surgical procedures, where possible, and weighing the pros and cons of other therapy such as radiotherapy and chemotherapy.

4.3 A recent study in Victoria showed that 635 consecutive cases of breast cancer that occurred in a six-month period were treated by 200 surgeons, 61% of whom treated only one to four patients a year, and that there was great variation in the work-up and management of patients. It would be wrong to develop a population-based screening programme without making effective moves at that same time to develop greater expertise in the assessment and management of patients. Many tiny cancers are found on mammography, and their treatment is a novel professional activity with many unknown factors operating. Unless attention is paid to assessment and management, not only will the possible benefits of screening be negated in terms of womens' lives saved, but client dis-satisfaction will lead to lower screening attendance rates.

4.4 The Victorian pilot project is showing that much effort (and consequent cost) is involved in educating and persuading women to attend for screening, and in maintaining a high level of satisfaction among clients. At this stage the findings show that in order to obtain even a relatively low attendance rate of 50-60% among eligible women aged 50-69, personal approaches by letter are necessary. It will not be possible to cost this activity sufficiently accurately to provide valid estimates for another six months. And it is not known whether recruitment for repeated screening, which will be needed every two or three years, will be more or less expensive than recruitment for the initial screening. It would therefore be unwise to promote screening facilities on a large scale until the skills and costs needed for education and recruitment of the population of women at risk are clearly established.

5. Recommendations

5.1 A limited number of centres for assessing breast problems should be established in Victoria. Initially up to three should be envisaged. They would be centres of excellence and provide a gold standard against which assessment and management in other facilities would be measured.

5.2 All screening mammography facilities should be accredited. The basis for accreditation should be that they will operate according to the rules laid down by the Radiation Safety Advisory Committee and the professional guidelines of the Royal Australasian College of Radiologists.

5.3 Screening mammography facilities should be organisationally associated with one of the breast assessment centres identified in 5.1 above. There should be no stand-alone screening facilities.

5.4 Mammography screening units promoted initially should be pilot ones closely associated with an assessment centre. In determining their sites, account should be taken of the expertise already developed at the RMH-ACCV program at Essendon and the obligation resting on that program to ensure repeated screening of the women already recruited to it.

5.5 Mammographic screening of individuals should be recorded and the outcome registered. To this end a central coordinating agency should be created in the State in which data from all screening units should be registered.

5.6 The registry should have a capacity to undertake a recall service so that women may be reminded when re-screening is due.

5.7 Screening records should be able to be linked to Cancer Registry data.

5.8 *In planning the development of mammographic screening in Victoria, the budgetary implications of all the activities mentioned above should be taken into account, not just the cost of the screening procedure itself.*

STATISTICAL NOTES

(Attachment to Report to the Minister of Health - 16 May 1990)

Incidence

In 1985 there were 1612 new cases of breast cancer diagnosed in Victorian women; 278 (17% in women aged 40-49, 717 (44%) in women aged 50-69, and 452 (28%) in women aged >69. In 1985, there were 356,565 Victorian women aged 50-69.

Deaths

In 1985 there were 661 deaths from breast cancer in Victorian women; 74 (11.2%) in women aged 40-49, 310 (46.9%) in women aged 50-69, and 250 (37.8%) in women aged > 69.

Essendon Breast X-Ray program experience

10,682 women have beeen screened after 17 months of the Program's 24 months of operation.

Up to 225-250 women have been screened per week (and the necessary follow-up investigations performed), with 2 mammography machines, and 12.5 full-time-equivalent staff (excluding those working solely on research).

13% of women screened have been recalled, either because of abnormalities in the mammogram, technical problems or reported symptoms.

Active recruitment has been necessary, including personal letters, to achieve at best 50-60% attendance of eligible women.

Early attenders at a program are likely to be atypical - more likely to be English speaking, have a family history of breast cancer, and be symptomatic. A rate of cancer detection valid for the general population is not therefore yet established.

A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB BS, Hon. LL.D, FRACP, FRACMA

Anti-Cancer Council of Victoria

January 24 1990

49-1720

Ms Joan Lipscombe
Acting Assistant Secretary
Health Care Strategies Branch
Department of Community Services and Health
PO Box 100
PHILLIP ACT 2606

Dear Ms Lipscombe

I read your letter of January, 19 1990 to Dr Stephen Duckett regarding provision of data by the Essendon Breast X-Ray Program to the national evaluation of screening mammography, and an undated memo, apparently from Mr. Chris Stevenson to Mr Steve McGinness of your department, about the same matter. Copies of these letters were sent to me by Mr Ian Russell.

I am quite concerned about this correspondence as it is not consistent with the agreement which we have made directly with Dr Michael Fett. I attach copies of the relevant correspondence in which you will see that the data was to be provided to SECU in the form of reports, rather than as the tabulations initially requested. The relevant correspondence, which was achieved after a number of painstaking and careful meetings, clearly sets out the agreement between Susan Hurley and Michael Fett as to the way in which the data is to be provided.

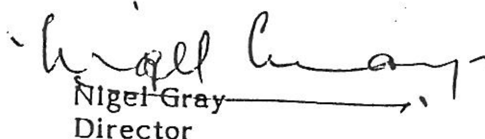
Based on this correspondence, I have been resting on the comfortable assumption that the material we have available is both appropriate and suitable. I am aware that the material which was prepared by Susan Hurley on December 19 1989, has not yet been received in Canberra as it awaits some final consultations between Ian Russell and Susan before it is in its final form. The final copy will be available very soon.

I would greatly appreciate a rapid response to this letter as I would not like to find that there is a misunderstanding between ourselves and SECU. I note from the letter signed by yourself to Stephen Duckett that funds appear to be held up because the Anti Cancer Council is not providing data in the tabulated form which was initially requested by SECU. My understanding is that SECU has agreed to receive the data in the form provided by us and it causes me some apprehension to discover that funds are being held up because data is not being provided.

The implication of your letter might appear to be that Michael Fett was not authorised to conclude the agreement he made with us. If this is the case I need to be told about it as a matter of urgency because I have proceeded in good faith, as have all my staff.

I will look forward to your early reply.
Best wishes.

Yours sincerely,



~~Nigel Gray~~
Director

cc. Mr Steve McGinness, Dr Stephen Duckett, Mr Ian Russell, Dr David Campbell and Dr Michael Fett
Encls.

KEOGH HOUSE, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053 ☎ (03) 662 3300
Facsimile: (03) 663 3412 Telex: ACCV AA 34158

?2nd January 1990

Ms. Susan Hurley,
Anti-Cancer Council of Victoria,
1 Rathdowne Street,
CARLTON 3053

Dear Susan,

I enclose a copy of a letter from the Acting Assisting Secre
the Health Care Stratergies branch of the Federal Health Dep
to Dr. Stephen Duckett.

I have copies of the tabulations requested by SECU. If you d
have cop es of them I will be happy to make them avaiable f

It is my wish that these tabulations be completed and I wo
you to provide the necessary data for their completion.

If you are not able to provide all the data requested please
specify:

1. Which tabulations can be completed now.
2. The precise steps which we need to follow to complete
   data tabulations indicating resources and personnel t
   might be required for this task.

Please reply to this letter as a matter of urgency.

Yours sincerely,

IAN S. RUSSELL
PROGRAMME DIRECTOR

cc - Dr. Nigel Gray - Director - ACCV
cc - Dr. D. Campell, Director Medical Services, RMH

AUSTRALIAN INSTITUTE OF HEALTH

GPO BOX 570, CANBERRA, ACT 2601. PHONE (062) 43 5000. FAX (062) 57 1470
THE INSTITUTE IS LOCATED AT BENNETT HOUSE, HOSPITAL POINT, ACTON, ACT

Chris Stevens
(062) 43502
Doc. Stevenson/478
File No. 89/47

Mr Steve McGinness
Financial Strategies Branch
Department of Community Services and Health
2nd floor
Alexander Building

Dear Steve

Here, as we discussed, are three copies of each of the da
tabulations that we requested from the mammography pilot

The Essendon Breast X-Ray project has not provided any c
data tabulations in the form that we requested. However
provided us with some reports which contain some of the
data. These reports are:

- Monthly attendance summaries: these contain data whic
some of the totals for the epidemiology and service d
tables IV and V, but no data classified by the age o
screened women.

- Behavioural Science research reports: Several of the
just before Christmas and may contain some of the re
data. Rosemary Knight arrived back from leave today a
I will go through them and I will let you know what w
However, this will probably take us a few days.

No data on the economic evaluation has been received from
project.

Tables relating to re-screening are not yet applicable (si
project has not been operating long enough to generate an
re-screening). These are Tables VI, VII, VIII, IX, XI, XI
and XVIII for Epidemiology and Service Delivery; Tables X
XIV for Behavioural Science and Table III for Economic co
service providers.

88/15893

Dr Stephen Duckett
Regional Director
West Metropolitan Region
Health Department Victoria
GPO Box 4057
MELBOURNE VIC 3001

Dear Dr Duckett

**CONTRIBUTION OF DATA BY ESSENDON HOSPITAL BREAST X-RAY PROG
THE NATIONAL EVALUATION OF SCREENING MAMMOGRAPHY**

I refer to your telephone call of 30 November 1989 to Ms Be
this Branch seeking a specification of exactly what is requ
enable payment of further instalments of the Commonwealth g
your department for the evaluation of the Essendon screenin
program. I regret the delay in replying.

The terms and conditions of the grant require that a projec
be submitted specifying, inter alia, what data will be prov
the Screening Evaluation Co-ordination Unit (SECU) at the
Australian Institute of Health. Once the project plan has
approved by this Department, an instalment of the grant wo
paid, and further payments would be conditional on timely
provision of the data. To date the project plans submitte
not been satisfactory in these respects as well as others.

Enclosed are copies of the data tabulations which SECU seek
the purposes of the national evaluation. As indicated by th
of the covering letter from SECU, some of this data has been
provided, but not in the desired form, and some tabulations a
not applicable until re-screening begins.

If agreement can be reached by <u>all</u> parties, including all rel
people employed by or associated with the Anti-Cancer Counc
Victoria, on which of these tabulations would be provided in
completed form (either on paper or in appropriate electron
media), and when they would be provided, it is likely that
other issues in approving the project plan would be easily
resolved.

Since the initial report of the national evaluation must be drafted in the near future, and the Essendon project could ma[illegible] major contribution to the development of policy in this field [illegible] should be grateful if you would seek the appropriate agreeme[illegible] a matter of urgency.

I am sending a copy of this letter and the tabulations to M[illegible] Russell of the Breast X-Ray Program.

The contact officer in this Department in relation to this ma[illegible] is Steve McGinness, telephone 062-89 7363.

JML

JOAN LIPSCOMBE
ACTING ASSISTANT SECRETARY
HEALTH CARE STRATEGIES BRANCH
19 January 1990

Director: Graham G. Giles Ph.D

Cancer Epidemiology Centre

Victorian Cancer Registry

24th November, 1989

Dr. Stephen Duckett,
Health Department of Victoria,
555 Collins Street,
MELBOURNE 3000

Dear Stephen,

I enclose a complete set of correspondence with Michael Fett regarding provision of data, as per your discussion with Dorothy Reading.

Please telephone me if you would like to discuss this further.

Yours sincerely,

Susan Hurley

Susan Hurley,
Epidemiologist,
Cancer Epidemiology Centre.

Enc.

ANTI-CANCER COUNCIL OF VICTORIA 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053
☎ (03) 662 3300 Facsimile: (03) 663 3412 Telex: VCCG AA 34158

A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB. BS. Hon. LL.D. FRACP. FRACMA

Anti-Cancer Council of Victoria

CC: SH

18 July 1989

BST-C-01/1

Dr E A Hewitt
Administrative Radiologist
X-Ray Department
Middlemore Hospital
Private Bag
Otahuhu
NEW ZEALAND

Dear Dr Hewitt

Thank you for your letter of 6 July in which you seek advice or information on the protocols, etc, that we use for our pilot breast screening program.

We are running a pilot project on mammography screening here at present. This is in association with the Amalgamated Melbourne and Essendon Hospital. The Anti-Cancer Council of Victoria is responsible for the recruitment side and also for the assessment of outcome. The Hospital is responsible for the radiography, interpretation of films and the subsequent management if necessary.

I enclose some of the protocols and materials that have been developed for this pilot project. It is a two year delivery program at the end of which an assessment of response and outcome will be made. We are trying to persuade the Commonwealth Government not to make any precipitous decisions about mammography prior to the outcome of this pilot project and a number of others that are going on around Australia.

I hope that the enclosed information is of some value. Susan Hurley of the Cancer Epidemiology Centre here is in charge of the evaluation. Dorothy Reading, Director of Education at this Council is in charge of the recruitment side. If you require further information on either of these areas, you could write to either or both of them.

Wishing you all the best.

Yours sincerely

Dr Robin Marks
Director of Programs

Enc

KEOGH HOUSE, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053 ☎ (03) 662 3300
Facsimile: (03) 663 3412 Telex: ACCV AA 34158

Director: Graham G. Giles Ph.D
Cancer Epidemiology Centre

57-1r-05/5

August 25, 1988

Dr S J Duckett
Regional Director
Health Department Victoria
GPO Box 4057
Melbourne 3001

Dear Dr Duckett

Please find enclosed two copies of the latest version of the Breast X-Ray Program Protocol (Version 2 - August 1988).

More copies are available if required.

With kind regards

Yours sincerely

Georgina Chambers
Project Officer

ANTI-CANCER COUNCIL OF VICTORIA, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053
(03) 662 3300 Facsimile: (03) 663 3412 Telex: VCCG AA 34158

ANNEX B

ATTENTION: Australian Surveying & Land Information
Dept of Administrative Services

FROM: Anti-Cancer Council of Victoria

The data supplied under order number 10620 (derived postcodes for Victoria in digital format) will be used to produce maps illustrating the following:

- Demographic data related to target populations for Victorian pilot mammographic screening projects

- Attendance data for the above projects

- Cancer incidence and mortality

THIS AGREEMENT IS MADE the ..EIGHTEENTH........day of.MAY.......
One Thousand Nine Hundred and Eighty-EIGHT between THE COMMONWEALTH OF AUSTRALIA (hereinafter called 'the Commonwealth') of the one part, and

......ANTI-CANCER..COUNCIL..OF..VICTORIA..............
(hereinafter called 'the applicant') of the other part.

WHEREAS

A. The Commonwealth has in its possession and is the owner of the copyright in certain digital data (hereinafter called 'the data') which is described in the Schedule annexed hereto and marked with the letter 'A';

B. The applicant wishes to make use of the data for those purposes described in the Schedule annexed hereto and marked with the letter 'B'; and

C. The Commonwealth and the applicant have agreed that subject to the terms of this agreement a copy of the data shall be released to the applicant.

Now in consideration of the sum of ....$100.00.......... paid by the applicant to the Commonwealth IT IS HEREBY AGREED as follows:-

1. The Commonwealth shall supply to the applicant a copy of the data.

2. The data and the copyright therein shall remain the property of the Commonwealth.

3. (1) The applicant shall treat the data as private and confidential and shall take all reasonable steps to keep the data private and confidential. To this end the applicant shall:-

(a) maintain a system for the safe custody of the data and copies of the data;

(b) copy the data for its own purposes only;

(c) disclose the data only to those of its employees whose duties require a knowledge of, or access to, the data and take all reasonable steps to minimise the risk of disclosure of the data by those employees.

(2) Except as provided in this Agreement, the applicant shall not, without the prior written consent of the Commonwealth disclose the data to any person or corporation and, if that consent is given, the applicant shall make known to the person or corporation to whom the data is disclosed that the Commonwealth is the owner of the data and the copyright therein and shall require that person or corporation to give to the applicant a written undertaking that it shall observe and perform with respect to the data terms and conditions similar to those contained in this Agreement.

4. If the applicant uses the data to produce materials which are to be disclosed or made available to a person or a corporation other than the applicant or its employees, the applicant shall make known to that person or corporation that:-

   (a) the data was used to produce the materials; and

   (b) the Commonwealth is the owner of the data and the copyright therein.

5. Without the prior consent in writing of the Commonwealth, the applicant shall not, and shall ensure that its employees shall not, use the data for any purposes other than those set out in Schedule 'B' hereto.

6. The Commonwealth does not warrant that the data does not contain errors and the Commonwealth shall not be in any way liable for any loss, damage or injury suffered by the applicant or any other person or corporation consequent upon the existence of errors in the data.

7. The applicant agrees to indemnify the Commonwealth and its officers and employees in respect of all claims for loss, damage or injury suffered by the applicant or any other person or corporation resulting from the use by the applicant or by that person or corporation of the data or any part thereof or of materials produced from the data.

8. If the applicant discovers any errors in the data or makes any modification or improvement therein it shall forthwith inform the Commonwealth accordingly and the Commonwealth shall be entitled to make use of that information, modification or improvement.

9. This Agreement may be terminated at any time by either party giving to the other three months' written notice of termination and may, in any case, be immediately terminated by the Commonwealth,

   (i) if the applicant commits, or allows to be committed, a breach of any of the provisions of this Agreement; or

   (ii) if the applicant becomes insolvent or, in the case of a company, is made the subject of winding up proceedings, whether voluntary or compulsory,

   and any termination of this Agreement shall be without prejudice to the rights of the Commonwealth which may have accrued up to the date of such termination.

10. (i) Any notice or communication under or in relation to this Agreement shall be deemed to have been duly given or served if it is in writing and posted in a prepaid letter addressed to the party to which it is to be given and shall be deemed to have been delivered in the ordinary course of post.

(ii) Notices or communications by the Commonwealth to the applicant shall, unless otherwise notified by the applicant to the Commonwealth, be addressed to :-

..CANCER..EPIDEMIOLOGY.CENTRE

.ANTI-CANCER...COUNCIL.OF.VICTORIA

....1 RATHDOWNE...STREET.......

....CARLTON..VIC..3053.......

(iii) Notices or communications by the applicant to the Commonwealth shall, unless otherwise notified by the Commonwealth to the applicant, be addressed to :-

Manager
Surveying and Land Information Group
PO Box 2
Belconnen ACT 2616

11. On the termination of this Agreement the applicant shall return to the Commonwealth the data and all copies thereof which are in the possession or under the power, or control, of the applicant and thereafter the applicant shall not use the data.

12. This Agreement shall be governed by and construed in accordance with the laws of the Australian Capital Territory.

IN WITNESS WHEREOF this Agreement has been signed by the parties as at the day and year first above written.

SIGNED for and on behalf of THE COMMONWEALTH OF AUSTRALIA)

by)

the Department of Administative Services, Surveying and Land Information Group)

in the presence of)

Signed for and on behalf of)

by)

in the presence of)

Witness

Director Graham G. Giles Ph.D.

Cancer Epidemiology Centre

12th April, 1988

Mr. Tony Webb,
Census Liaison Officer,
Australian Bureau of Statistics,
GPO BOX 2796 Y
MELBOURNE 3001

Dear Mr. Webb,

I would like to request tabulations on magnetic tape (1600 bpi, ASCII, unlabelled) from the following 1986 census data, as discussed in our telephone conversation on the 11th April 1988.

(i) Country of birth (table 1) for females, by 5 year age group, by postcode, by period of residence in Australia (0-4 years and 5 years & over) for 31 specified postcodes (table 2)

(ii) Language spoken at home (table 3) for females, by 5 year age group, by postcode, for 31 specified postcodes (table2).

As you may know through past correspondence with Susan Hurley we intend to use these data for planning and evaluation of mammographic screening programs, which will commence in Victoria.

Pleae don't hesitate to contact me with any queries.

Thank you very much for your assistance.

Yours sincerely,

Georgina Chambers,
Project Officer,
Essendon & District Mammographic
Screening Program.

ANTI-CANCER COUNCIL OF VICTORIA, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053
☎ (03) 662 3300 Facsimile: (03) 663 3412 Telex: VCCG AA 34158

TABLE 1

COUNTRY OF BIRTH (BPL)

COUNTRY	CENSUS CODE
Australia	1
New Zealand	8
UK & Ireland	16-20
Greece	22
Italy	23
Yugoslavia	27
Other European	29-44
USSR	45-49
Eastern Asia	50-54
Indonesia	56
Kampuchea	57
Malaysia & Brunei	59
Phillipines	60
Thailand	62
Vietnam	64
Lebanon	75
Turkey	77
Not Stated	99
All other	Other

TABLE 2

POSTCODES REQUIRED FOR TABULATION

3011	3031	3043	3057
3012	3033	3044	3064
3013	3034	3046	3427
3019	3036	3047	3429
3020	3038	3048	
3021	3039	3049	
3022	3040	3051	
3023	3041	3055	
3032	3042	3056	

TABLE 3

LANGUAGES SPOKEN AT HOME (LAN)

LANGUAGE	CODE
Aboriginal	1
Arabic	4
Chinese	9
German	20
Greek	21
Indonesian/Malay	24
Italian	25
Korean	28
Maltese	33
Polish	36
Spanish	46
Thai	50
Turkish	52
Vietnamese	55
Yugoslav	58
Not Stated	65
Others	Others

57-lr-05/5

March 11, 1988

Dr. Mary Rickard
Director, Breast X-ray Programme
Rachel Forster Hospital
P.O. Box 178,
Redfern. NSW 2016

Dear Mary,

Thank you very much for showing me around your mammography screening programme last Wednesday. I appreciated the time you spent with me (especially during your first week of operation!) and I was very impressed with your programme.

As I mentioned, I will telephone you in a week or so to discuss a tentative price for your computer program. We would need to make some local alterations, and knowing the price would assist us in deciding if it is worthwhile modifying your program, or if we should start from scratch.

Thank you once again, and best wishes for the success of your programme.

Yours sincerely

Susan Hurley
Epidemiologist

57-lr-05/6 March 11, 1988

Dr Paul Glasziou
Research Fellow
Ludwig Institute for Cancer Research
Blackburn Building
University of Sydney
Camperdown. NSW 2050

Dear Paul,

Thank you very much for showing me the Rachel Forster computer program last Wednesday. I felt honoured to be the first to see it running on-site and was very impressed that it worked so well!

I enclose a floppy disk for the copies of the .exe files you promised to send me in a few weeks. Thanks once again.

Yours sincerely,

Susan Hurley
Epidemiologist

PS I would also appreciate receiving a copy of the paper on CMF and utility analysis you mentioned, please.

COPY

57-lr-05 March 8, 1988

Mr. Tony Webb
Census Liaison Officer
Australian Bureau of Statistics
GPO Box 2796Y
Melbourne. 3001

Dear Mr. Webb,

I would like to request a tabulation on magnetic tape (1600 bpi, ASCII, unlabelled) of the following 1986 census data:

> Country of birth for females, by 5 year age group, by postcode, by period of residence in Australia (0-4 years and 5 years & over) for all postcodes in Victoria.

We intend to use these data for planning and evaluation of mammographic screening programs, which will start in Victoria soon.

I discussed this request on the telephone with Mr. John Ericson on March 4 and he suggested that I make a written request, and you would then advise me of the feasibility and costs (if any).

Thank you very much for your assistance,

Yours sincerely

Susan Hurley
Epidemiologist

COPY

57-1r-05/4

March 23, 1988

Ms Leanne Clavarino
Medical Administration
Royal Melbourne Hospital
Amalgamated Melbourne & Essendon Hospital
Post Office
Victoria. 3050

Dear Leanne,

As discussed, I enclose 7 copies of the mammographic screening draft protocol for discussion at the March 30th meeting. We have distributed copies to the ACCV staff attending the meeting and have also sent a copy to Dr Billson. Would you please send copies of the agenda and any other attachments to Susan Fitzpatrick for distribution at the ACCV.

Our suggestions for inclusion on the March 30th agenda are as follows:

1. Draft protocol. Items requiring discussion & confirmation

   1.1 Level of investigation at which program stops (before or after surgical biopsy) pages, ii, 9/10

   1.2 Triage of women with previous breast cancer, page 9

   1.3 Timescale for reading of mammograms, page 9

   1.4 Referral to RMH Breast Clinic, page 10

   1.5 Assignment of UR Nos., page 11

   1.6 Other

2. Access to childminding facilities

3. Optical scanning for data entry

With best wishes,

Yours sincerely

Susan Hurley
Epidemiologist

COPY

57-lr-05/3

March 23, 1988

Dr Virginia R Billson
Department of Anatomical Pathology
Royal Melbourne Hospital
Post Office
Victoria 3050

Dear Dr Billson

Thank you very much for your letter of March 18th, and for providing so promptly the information on cytology and histopathology services for the Essendon & District mammographic screening program. I have incorporated the material you provided, in a slightly abbreviated form, in the draft protocol for the program (enclosed). Please let me know if you have any comments on the protocol in general, and the cytology/histopathology section in particular.

As I mentioned last Thursday, the draft protocol will be discussed at a meeting of the AMEH-ACCV interim program management committee on Wednesday March 30th.

Thank you once again for your assistance.

Yours sincerely

Susan Hurley
Epidemiologist

THE AMALGAMATED MELBOURNE & ESSENDON HOSPITALS

REGISTERED — 1934

INCORPORATING

THE ROYAL MELBOURNE HOSPITAL

&

ESSENDON HOSPITAL

Postal address: C/o Post Office, The Royal Melbourne Hospital, Victoria 3050, Australia.
Telephone: (03) 347 7111 Telex: RMHOSP AA37708 Facsimile: (03) 347 4558

QUALITY CONTROL PROCEDURES FOR CYTOLOGY AND HIST[illegible]

AMCH - ACCV [illegible] MAMMOGRAPHIC SCREENING [illegible]

CYTOLOGY

Quality control with respect to Cytology section [illegible] under five headings:

a - Patient and specimen identification
b - Cytology screening interpretation and consultation [illegible]
c - Correlation of cytologic and histopathologic diag[illegible]
d - Qualifications and quality of scientific staff [illegible] practitioners
e - Quality control of the technical aspects of cyto[illegible]

a - The patient demographic details which are [illegible] request form are correlated with the specimen [illegible] sequential accession number (SID No.) is given to each [illegible] printed sequential labels are adhered to the request [illegible] container and demographic details are then entered in[illegible] All slides from this one case are subsequently label[illegible] No. throughout any further [illegible] and storage proce[illegible]

b - All screening is perf[illegible]ed by an appropriately qual[illegible] cytologist, screener with a bachelor of Applied Scien[illegible] qualification. All abnormal slides are screened by [illegible] cytologists and a report is written and entered into [illegible] the scientific staff. All cases both positive and [illegible] sent to the duty pathologist on a daily basis and the [illegible] slides are checked by the pathologists who authorise [illegible] the results. All cytopathology cases and especially [illegible] abnormal are therefore screened at least twice and [illegible] three times before being authorised for release.

c - With the advent of [illegible] reporting [illegible] it is now possible to [illegible] cytology and histology. In addition we [illegible] careful follow-up of all cytologic diagnoses [illegible] that have been followed by tissue confirmation [illegible] those cytology cases that have negative di[illegible] procedures are performed as follows:

[illegible] all cases received [illegible] at three monthly intervals. These random samples [illegible] is carried out at least four times a year [illegible] first quarter is followed-up in the second quarter [illegible] in the second quarter is followed up in the [illegible] Data obtained from all these methods of [illegible] and tabulated.

[illegible]

THE AMALGAMATED MELBOURNE & ESSENDON HOSPITALS

REGISTERED — 1986

INCORPORATING

THE ROYAL MELBOURNE HOSPITAL

&

ESSENDON AND DISTRICT MEMORIAL HOSPITAL

March 21, 1988.

Mrs Susan Hurley,
Cancer Epidemiology Centre,
1 Rathdowne Street,
CARLTON VIC. 3053

Dear Susan,

In your letter of March 4, you referred to item 6 and item 10 of the attached summary of discussions but they do not seem to tie up well with your text. However, I believe there are three questions you are asking. The first relates to quality control, the second, item 10, relates to the Rachel Forster programme and the third asks who will look after things whilst I am away.

The quality assurance side can be listed as follows:

1). Daily sensitrometric film strip testing for processor control
2). Regular, probably six-monthly, equipment check according to NCRP checklist provided by NHTAP
3). Checks on reporting by matching radiologists' codes with recall rates, and for each radiologist such parameters as recall/biopsy ratio and recall/carcinoma ratio.

As regards the Rachel Forster forms I am not happy with the mammographic screening report form. The two faults are that in certain ways it gives too little information and in others, the so-called features, it attempts to give too much. The general form I would prefer not to comment on as it depends what people other than the radiologists are interested in collecting.

Whilst I am away Dr Neale Walters of this Department will be the contact person and I will appraise him of the various aspects which are likely to arise in my absence. He will be one of the mammography readers so he is personally involved.

With best wishes,

Yours sincerely,

Bill Hare

W. S. C. HARE
Director of Radiology

Postal address: C/o Post Office, The Royal Melbourne Hospital, Victoria 3050, Australia.
Telephone: (03) 347 7111 Telex: RMHOSP AA37704 Facsimile: (03) 347 4558

EVALUATION OF AMEH MAMMOGRAPHY PROJECT

Round Table Conference

9.30 am - Friday, March 4, 1988 - ACCV

Present: Ms C Giles, Head, Women's Health Policy Unit, Health Department
Dr M Fett, Epidemiologist, AIH Screening & Coord. Unit
Ms R. Knight, Psychologist, AIH
Dr G Giles, Dr D Hill, Ms S Hurley, Ms D Reading, Prof R Lovell,
Dr D Campbell, Ms L Clavarino and Mrs S Fitzpatrick

Professor Lovell opened the meeting thanking those present for coming and fitting this meeting into their busy programs.

Professor Lovell stated that this meeting, at the instigation of Christine Giles, had been called to discuss the relationship between local and AIH evaluation of the AMEH project.

1. Introduction by C Giles

Important that all parties meet and are brought up to date with relation to evaluation of projects. Commonwealth Government published two reports through Health Advisory Council. Breast and Cervix - piloting projects around Australia with view of coordinating work for future long term screening. Development of a National Coordination Unit.

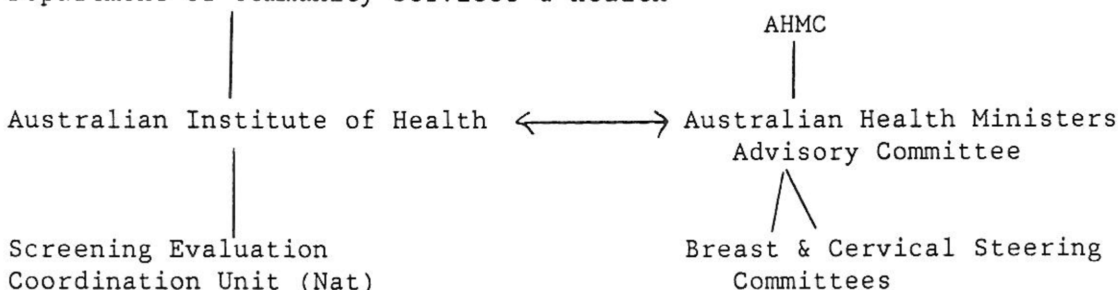
Health Department accepted invitation to sit on AHMAC sub-committee. Health Minister discussed with ACCV evaluation and funding of AMEH project.

Professor Lovell advised that two years ago ACCV discussed recommendations of Lovell report and it reviewed all possible steps to prevent cancer. A Breast Summit meeting was held with representatives of all states and it recommended national collaboration.

2. Status of national evaluation body

Dr Michael Fett referred to the report of the Working party on the evaluation of breast cancer screening projects to the AHMAC sub-committee on breast and cervical cancer screening dated 12 November, 1987. The key recommendation was that resources for women's health be provided for breast and cervical evaluation. A budget of $5 million was provided.

Department of Community Services & Health



The steering committees and pilot projects are to produce recommendations for the Commonwealth Government for national screening programs, especially noting costs, delivery and funding etc.

The AIH is independent of State authority.

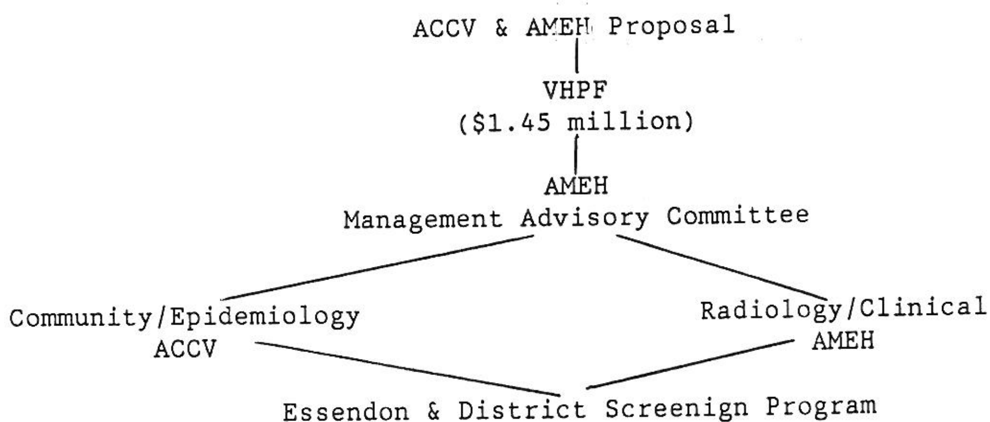
Money for evaluation of breast cancer screening pilot projects that have been approved by the states. The Dept Comm Services & Health will provide a seeding grant of $10,000 for the State Health Departments to develop detailed proposals for evaluation, which should be submitted for the current financial year.

3. Status of AMEH

Professor Lovell outlined the background to the development of the AMEH program. The project proposal was a result of the joint collaboration of AMEH and ACCV. The Victorian Health Promotion Foundation agreed to fund the project to the amount of $1.45 million over three years.

The final details are to be finalised. Medical aspects such as radiology, pathology, surgery to be handled by AMEH. Non-medical aspects such as computing, epidemiology, education to be handled by ACCV. The AMEH Board of Management to approve procedure and implement management committee.

It was noted that there should be collaboration with SECU and that the AMEH program maintain its in-house evaluation. It was important to maintain patient confidentiality when cooperating with outside bodies.



It was noted that the AMEH proposal was approved by the Minister for Health, but he does not intervene in the project. Future projects will be based on knowledge of AMEH program.

4. Plans of national body for evaluation

(a) What is requested

The Dept. Community Services & Health to provide $10,000 to State Government to assist in the development of proposal to be submitted to DCSH by end of March. Members of SECU available to assist projects in developing proposals for submission through State Government to DCSH.

It was noted that AMEH was a free standing independent project. SECU should formally advise AMEH of request and outline general principles.

Dr Fett referred to item 5 of the Report (p.13) 'Issues for a

nation-wide screening programme'; item 6 (p.15) 'Common features of pilot projects'; item 7 (p.17-20) 'Design options".

A working manual for the AMEH program was currently being prepared, and as yet the Management Advisory Committee had not been appointed. Neither the Project Officer or the Project Manager had been appointed.

It was suggested that as the project develops Dr Fett should be invited to discuss evaluation.

(b) <u>What is offered</u>

Christine Giles stated that the DCSH ad hoc funding committee consisted of M. Ford, B. Armstrong and herself and that it would be meeting in the near future. The proposals received would be measured against policy papers. The Victorian model was highly regarded. Individual projects were to submit applications through State Government for evaluation by SECU. Project evaluation would then be between the project and SECU.

The question of side research projects which could be funded at intervals was raised. This was thought to be a favourable avenue for funds for extra projects.

Reference was made to page 27 of the Report 'Measuring the effectiveness of pilot projects'. Particular reference was made to 'Performance measures for national evaluation', and Appendix 3 'Main basic data set'.

It was noted that AMEH was financially free-standing, and that a variety of possible sources were available for additional funding if needed, and now a further source of funds was available for evaluation.

It was agreed that the Department of Community Services and Health should write to the Executive Director, Mr. J. Tribe, AMEH, indicating that if funds for evaluation were required to please advise accordingly.

It was understood that the national screening program was desirable.

VICTORIAN
COOPERATIVE
ONCOLOGY GROUP

Executive Secretary : Professor Emeritus R.R.H. Lovell

57-lr-00/3 December 23, 1987

Dr. D. Campbell
Medical Director
Royal Melbourne Hospital
Post Office
Victoria. 3050

Dear Dr. Campbell

Re: **AMEH ACCV Mammographic Screening Project**

Dr. Nigel Gray has asked me to write to you about this project. The proposal for funding was presented to the Victorian Health Promotion Foundation meeting two weeks ago. A decision on it was deferred pending the annswer to a question about the management of people screened positive.

Dr. Gray undertook to discuss the concerns that were expressed with the member of the Foundation who raised them. He has now had this discussion and the proposal will be reconsidered at the next meeting of the Victorian Health Promotion Foundation on January 20th, 1988. The objections raised could probably be overcome if prior to that date a statement could be developed (that might be appended to the study protocol) to indicate how, following accurate diagnosis, patients may be completely informed of their condition and of the treatment options available to them. In this connection a process might be considered for external review of this aspect of the project as it develops.

I write to ask if, despite the season of the year, it would be possible for Dr. Gray to be supplied with such a statement that he can quote in discussion at the next meeting of the Victorian Health Promotion Foundation.

Dr. Gray will be available through the coming weeks and would much appreciate your help.

Yours sincerely,

R. R. H. Lovell

c.c. Dr. Gray
Mr. Russell
Professor Clunie

57-lr-05/2

March 4, 1988

Professor W. Hare
Director of Radiology
Amalgamated Melbourne & Essendon Hospitals
Royal Melbourne Hospital
Post Office
Victoria. 3050

Dear Professor Hare,

I enclose a brief summary of our discussions of Monday 29th February, regarding the protocol for the Essendon & District mammographic screening program. I will send you a revised draft of the mammography recording form soon.

I would appreciate it if you could forward details of plans for quality control (item 6) to me by Wednesday 23rd March so that I can include a section on this subject in the protocol (to be discussed on 30th March). Also, it would be helpful if you could send me your thoughts on item 10 before you leave for overseas, and could nominate someone from your department with whom I can liaise during your absence.

The proposed meeting with Ian Russell is confirmed for Thursday 17th March, 6 pm at the ACCV and Virginia Bilson, John Collins and Le-anne Clavarino will also attend.

With best wishes,

Yours sincerely,

SH

Susan Hurley
Epidemiologist

cc Mr I Russell
Ms. L. Clavarino
Prof. R. Lovell
Dr. G. Giles.

Summary of discussions between Susan Hurley & Professor Hare

held on Monday, 29th February,

regarding protocol for Essendon & District Mamographic Screening Program

1. Screening will be by two view mammography. WH said that a randomised trial of single vs two view mammography was not an option.

2. Initially, films will be processed before women leave the screening centre.

3. Films will be read independently by two radiologists, on a daily basis, and each radiologist's interpretations will be recorded on computer. When there is disagreement about whether a woman should be recalled, a decision will be reached through consultation between the radiologists and the final decision will be recorded.

4. After the initial screening mammography, women will either:

   (a) receive an all clear letter;
   (b) be recalled for further mammography; or
   (c) be referred to a clinical assessment clinic (? with recommendations for investigations such as ultrasound)

   Abnormalities will not be investigated using ultrasound, pneumocystography etc. before referral to the assessment clinic. This plan requires discussion with, and confirmation by, the clinicians.

5. Women who present for screening and state that they have a breast lump will receive normal two view mammography <u>and</u> automatically be referred to the assessment clinic. Triage of women who present with other breast symptoms (eg bleeding from the nipple) requires discussion with the clinicians.

6. Policies for fine needle aspiration need to be determined in consultation with the clinicians.

7. WH will provide details of planned quality control and quality assurance procedures for the mammography machines, films and radiologists for inclusion in the protocol.

8. The Rachel Forster program recording form for patient details would be adequate for radiology requirements for the Essendon program.

9. Breast cancer risk factor information would not be required for interpretation of mammograms.

10. The Rachel Forster program recording form for interpretation of screening mammograms would not be suitable for the Essendon program. A draft recording form for Essendon was discussed.

11. Recording of information on recall mammograms needs further thought. WH agreed that the form currently used by RMH was probably too detailed for the screening program and undertook to produce a briefer version. The estimate of probability of cancer is one item that could be excluded.

The University of Melbourne
Research Centre
for Cancer and Transplantation

Department of Pathology

Professor I.F.C. McKenzie

29th September, 1987

Professor Emeritus R.R. Lovell
Executive Secretary
Victorian Cooperative Oncology Group
Anti-Cancer Council of Victoria
Keogh House
1 Rathdowne Street
CARLTON SOUTH VIC. 3053

Dear Dick,

Many thanks for your letter of September 21st which has clarified the situation. I think that Susan's visit was essentially an exploratory one at which I indicated our interest in participating. However, I see a number of problems for us. Firstly, I am concerned about the logistics of our doing 30,000 serum samples and think that this should only be done if it can be conducted on site at Essendon. Secondly, a study of this magnitude should really be catered for by Hoffman La Roche (who are negotiating with the Australian company, which holds the licence for this test from University) and I have written to Dr. Christian Stahli, at Hoffman La Roche, to see if they are interested in this. If they are interested we will let you know.

I feel that it is important that the MSA test be examined for its value in a screening program but whether this be done in Australia or elsewhere remains to be seen.

Thank you for your interest.

With best wishes,

Yours sincerely,

Ian

Ian F.C. McKenzie, M.D., Ph.D.,
Professor

cc.
Mr. B. Williams
Ms. S. Hurley
Mr. I. Russell
Dr. J. Tjandra

Parkville, Victoria 3052, Australia. Telephone 03 / +61 3 344 5839 Telex AA35185 UNIMEL Cables UNIMELB

VICTORIAN
COOPERATIVE
ONCOLOGY GROUP

Executive Secretary : Professor Emeritus R.R.H. Lovell

57-lr-00 September 21, 1987

Professor I.F.C. McKenzie
Research Centre for Cancer & Transplantation
Department of Pathology
University of Melbourne
Parkville. Vic 3052

Dear Ian,

Susan Hurley has told me of her discussions with you about the possible development of a pilot mammography screening project based on the Amalgamated Melbourne and Essendon Hospital's. She has also told me of your potential interest in the possibility of a study of your MSA tests being grafted on to the project. I have seen the outline of your proposal in your letter to Susan of September 1st.

I thought I should let you know that, at this stage, the whole pilot project remains quite hypothetical. If funding encourages more detailed planning the emphasis in the first instance will be entirely on mammography. Any consideration of grafting on other research projects will, for some time, remain entirely speculative.

Yours sincerely,

R. R. H. Lovell

cc Mr. I.S. Russell

The University of Melbourne
Research Centre
for Cancer and Transplantation

Department of Pathology

Professor I.F.C. McKenzie

14th September 1987

Ms Susan Hurley
Epidemiologist
Cancer Epidemiology Centre
Anti-Cancer Council of Victoria
1 Rathdowne St
Carlton South 3053

Dear Susan,

Thank you for your letter of the 3rd of September. The only alteration I would make is that 3,500 blood donors have been examined, not just 2000. I would be grateful to find out how this is progressing, however in the meantime I am using your statement to help raise funds for this.

With best wishes,

Yours sincerely,

Ian F.C. McKenzie, M.D., Ph.D.,
Professor.

Parkville, Victoria 3052, Australia. Telephone 03 / +61 3 344 5839 Telex AA35185 UNIMEL Cables UNIMELB

The University of Melbourne

Research Centre
for Cancer and Transplantation

Department of Pathology

Professor I.F.C. McKenzie

September 1, 1987

Ms. Sue Hurley
Anti-Cancer Council of Victoria
Keogh House
1 Rathdowne Street
CARLTON VIC. 3053

Dear Sue,

Thank you for coming to see me on behalf of the Anti-Cancer Council of Victoria regarding our participation in the Screening Program to be conducted at the Essendon Hospital.

I would like to summarise our meeting as follows:

1. I believe that some time next year, 1988, a Screening Program will be established wherein over two years 30,000 females will be screened, by mammography, for the presence of breast cancer. I do not know the details of the screening but gather that this will be single film and that the studies are being co-ordinated by Mr. Ian Russell and Professor Bill Hare.

2. The proposal was that we would screen serum samples from these patients and provide you with the results of this serum test (MSA = mammary serum antigen). Although these results would be available for our analysis they would not be given to the patients.

3. Although the Victorian Government is considering funding the mammography side of the project there is no consideration that the MSA test will be funded and therefore you requested that we provide the funds for this.

(continued .../2)

Parkville, Victoria 3052, Australia. Telephone 03 / +61 3 344 5839 Telex AA35185 UNIMEL Cables UNIMELB

September 1, 1987

We would very much like to participate in this program and we are pleased by your interest, and that of the A.C.C.V., in the serum test.

You have copies of those manuscripts recently submitted on the M.S.A. test. The information which you will not have, but we told you verbally, is that of a recent trial conducted by Dr. Tjandra and myself in conjunction with Profesor Bill Hare, at the Royal Melbourne Hospital, on 100 patients with breast cancer. These patients were correctly diagnosed in 76% of cases by M.S.A. and in 42-505 of cases by mammography. In both studies there was 12-15% false positive scores.

At this time I am currently drawing up a budget, a rough budget has been enclosed for your information. I am also discussing possible sources of funding and would be grateful for your advice on this matter. I envisage several possible sources:- (a) the antibody used in the test has been licensed by the University to a company, Medical Innovations, who have sub-licensed this to another company, Integrated Medical Technologies Ltd. and a sub-license for distribution of the test has been signed with Hoffman La Roche. Any or all three of these companies could be asked to fund such a study. Indeed, Hoffman La Roche have requested a budget for this but I am not sure of the likelihood of this being funded. (b) there may be some organisations in Melbourne, with an interest in cancer, who may be prepared to fund this. (c) the A.C.C.V. may be able to append this budget to that requested from the Victorian Government for this project.

One further point to be clarified is whether the test can be done on site, at the Essendon Hospital, if so then overhead costs would not be allocated to the University (12.5% for total budget, excluding equipment).

Finally would it be possible for you to extend a "formal" invitation to participate - this would be of help in trying to raise the necessary funds.

Thank you again for your help in this matter and I look forward to discussing this further with you.

Yours sincerely,

Ian F.C. McKenzie, M.D., Ph.D.,
Professor

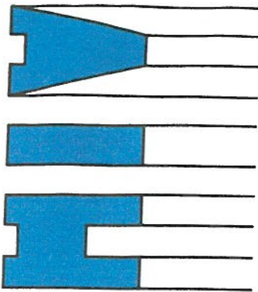
BUDGET FOR SCREENING TEST FOR MSA IN THE EARLY DETECTION OF CANCER

BASIS OF BUDGET

To test 30,000 subjects in two years, i.e. 15,000 per annum, 300 per week. As at present 24 samples fit on each plate, this would mean 13 plates per week.

	Year 01	Year 02
Staff		
Senior Technical Officer	27,205	27,624
Technical Officer	22,821	23,343
Total (incl. 11.32% overheads)*	55,689	56,736
Equipment		
Incubators	7,500	-
Weighing Machine	2,000	-
Homogeniser	6,000	-
Centrifuge	10,000	-
Computer Package		
Titretek Multiscan	35,000	-
Freezer	10,000	-
Miscellaneous (including glassware, vortex, pipettes)	10,000	-
Sub-Total	80,500	-
Maintenance (per 1000 subjects)		
Pipette tips	500	500
Tubes	500	500
Costar plates	400	400
Base	100	100
Conjugate	600	600
Medium, reagents	1,000	1,000
Tissue Culture Flask	1,000	1,000
Pasteur Capillary Pipettes	1,000	1,000
Antigen Plates	1,000	1,000
Monoclonal Antibodies	400	400
Miscellanous (including gloves and containers)	500	500
Sub-Total (per 15000 subjects)	105,000	105,000
Consultants' Fees	20,000	20,000
University Overheads (12.5% on all items except equipment)	22,710	22,717
TOTAL COSTS	**283,890**	**204,453**

*(incl. annual leave loading, payroll tax, worker's compensation, insurance and provision for long service leave)



AUSTRALIAN INSTITUTE OF HEALTH

—Contact

—ext.

—Ref.

Dr Sue Hurley
Anti-Cancer Council of Victoria
1 Rathdowne Street
CARLTON VIC 3053

Dear Sue,

Thank you for a copy of the Forrest Report, which I read with great interest. I am writing to you now at the direction of the AHMAC Working Party on Mammography Screening Evaluation to seek information about the proposal for a mammographic screening service based at the Essendon Hospital. The Working Party has identified, in a preliminary manner, the design options which it believes should be represented in one or more of the mammography pilot projects to allow for evaluation of all plausible methods of delivering mammography screening. These options are identifies on the attached list.

I would be grateful if you would examine the list in relation to the Victorian proposal and indicate (on the list if you wish) which of the design options listed would be represented in your programme. Also, an indication of any options which you are planning but which are not on the list would also be appreciated. I have taken the liberty of marking the list with the options which I understand your project plans to implement. An early reply would be much appreciated.

With best wishes,

yours sincerely,

Michael Fett

Dr Michael Fett

Secretary,
AHMAC Working Party on Breast Cancer Screening

4 Sept. 1987

GPO BOX 570 CANBERRA ACT 2601 PH. (062) 43 5000 FAX. 57 1470 Telex: AA62149
BENNETT HOUSE, HOSPITAL POINT, ACTON, A. C. T.

DESIGN OPTIONS

Recruitment

Target population

Upper socioeconomic status
Lower socioeconomic status
English speaking background
Non-English speaking background
Aboriginal background
Metropolitan
Rural

Identification of women to be screened

Electoral records
Alternative population registers

Education about mammography and screening resources

Local media and distribution of posters, pamphlets, etc
Networking e.g. womens groups, community organizations, ethnic or aboriginal networks
Health education groups
Health influential education oriented to referral and role of private care providers if any
Workplace based education
Targeted educator outreach and appointment system

Recruitment strategy

Individually targeted mail etc
GP referral
Drop in / self referral

Screening

Interval

2 years
3 years

Age

Different categories within the range 40+ 40 - 69 under discussion

Unit location

Fixed metropolitan
Mobile metropolitan
Combination of fixed and mobile metropolitan

Mobile rural —

Hours of operation

Working hours ✓
After hours / weekend ✓

Views per breast

One
Two ✓

Clinical examination

Present —
Absent —

Film processing

Local ✓
Centralized

Film reading

One reader per film with check reading
Two readers per film ✓

Film reader

Radiologist ✓
Non-radiologist

Diagnosis / Treatment

Referral to pilot project affiliated diagnosis treatment facility ✓
Referral to usual health care providers

Cytology diagnosis

One reader per patient with check reading
Two readers per patient

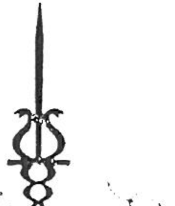
Pathology diagnosis

One reader per patient with check reading
Two readers per patient

to be determined

A member of the Australian Cancer Society
Director: Dr Nigel Gray A.M. MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria



August 13 1987 40-430/10

② cc Susan Hurley

Mr D. J. Slattery
Chief Executive Officer
Woorayl District Memorial Hospital
P.O Box 168
Leongatha 3953

Your ref - 4313

Dear Mr. Slattery,

Thanks for your note of July 29 about mammographic screening.

The situation at present is as follows -

1. The Council and the Amalgamated Melbourne and Essendon Hospital group have got together and designed a pilot project to establish the feasibility of quite a few specialist elements of a potential statewide screening program.

2. The Minister for Health has approved that project and asked Canberra to fund it. We are optimistic, despite current constraints.

3. The minister has also approved the establishment of a Mammographic Screening Advisory Committee by the Anti-Cancer Council. This committee has a broader function than the project committee for the pilot project mentioned above. It will recommend at least a couple more pilot projects and will consider the evaluation of the various components of that and other pilot projects and give the minister formal advice about the how, why, when and where aspects of the potential introduction of mammography on a wide scale.

   This committee will have its first meeting in September. I will bring your letter before it. I don't expect that we will be in a position to make much of a response for a couple of months after the committee's first meeting. For your information I am the chairman of this comittee.

Although I think we have taken all the important steps to set up the first pilot project and I am optimistic about funds; I am not so optimistic about funds for the second and third pilot projects which are obviously going to be essential and are needed pretty quickly. I.e. we may well be looking for groups in Victoria who are able and willing to provide funding for a community based project from their own resources as there is precious little free money in the health department these days.

In terms of the research program required to support the various pilot projects, it's possible that the Anti-Cancer Council can resource these - please don't take this as a commitment just yet!

Yours sincerely

Nigel Gray

Nigel Gray
Director

cc: R.Lovell+

KEOGH HOUSE, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053 ☎ (03) 662 3300
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3 1 JUL 1987

WOORAYL DISTRICT MEMORIAL HOSPITAL

P. O. BOX 168, LEONGATHA, VIC. 3953
TELEPHONE LEONGATHA (056) 62 2222

Your Ref.:

Our Ref.: 4313

29th July, 1987.

Dr. Nigel Gray,
Director,
Victorian Anti-Cancer
Council,
1 Rathdowne Street,
CARLTON. 3053

Dear Dr. Gray,

For some period of time now, the Committee of Management of this Hospital, in conjunction with the Victorian Imaging Group, has had an interest in the high rate of breast cancer within the South Gippsland sub-region. The Victorian Imaging Group has proposed that either a hospital based or mobile mammography unit be established within the area, this proposal has the full support of the Committee of Management of this Hospital.

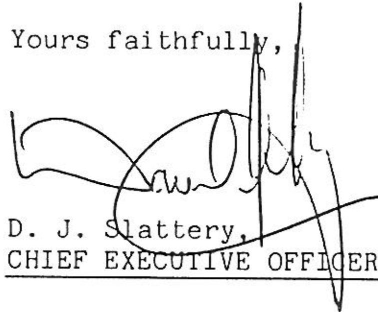
Leongatha is situated some 120 kilometres from Melbourne and is the main community centre in the local government area of Woorayl. The population base is approximately 12,000. The surrounding local government areas of South Gippsland, Mirboo and Korumburra provide a total catchment area to this sub-region of approximately 30,000. These communities are serviced by three public hospitals and one bush nursing hospital. The area is a discrete sub-region bordered by the Strzelecki Ranges and we believe it would be an ideal situation to conduct a pilot research project on the effects of a mammography service used in a preventative health programme.

Our Regional Director, Mr. Jim Menzies, has been notified of our desire to establish the programme within the area and has been requested to provide information regarding the most appropriate sources of funding available for both capital and ongoing costs for this project.

My Board is interested in seeking the support of the Anti-Cancer Council of Victoria in establishing a mammography service to this area. They would be interested in hearing from the Council as to whether a hospital based or community based, that is mobile service, would be most appropriate within the rural setting. Further to this, if the project could be established, would the Council be interested in providing assistance to establish a research programme based on the introduction of the new service.

Hoping that the Council will see this as a step in providing community awareness, prevention and early detection in breast cancer and will be able to provide us with the support required to establish this new service.

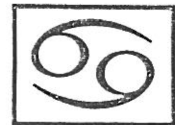
Yours faithfully,



D. J. Slattery,
CHIEF EXECUTIVE OFFICER.

DJS/JS
17:7(a)

Director: Graham G. Giles Ph.D
Cancer Epidemiology Centre



12th June, 1987

Professor John Forbes,
Professor in Surgical Oncology,
Newcastle Mater Misericordiae Hospital,
WARATAH NSW 2298

Dear John,

Further to our conversation regarding Dr. Tabar's visit, I have discussed the suggestion you made, about Dr. Tabar arriving at the Anti-Cancer Council of Victoria a little earlier than 5.00 p.m. on September 7th, with Professor Lovell. We think that it would be best for the previous arrangements to stand, ie. a 5.00 p.m. arrival. We will invite members of the epidemiology group along to Dr. Tabar's lecture, as you suggested, and there should be plenty of opportunity for questions after the lecture.

Kind regards,

Yours sincerely,

Susan Hurley

Susan Hurley,
Epidemiologist,
Cancer Epidemiology Centre.

ANTI-CANCER COUNCIL OF VICTORIA, 1 RATHDOWNE STREET, CARLTON SOUTH, AUSTRALIA 3053
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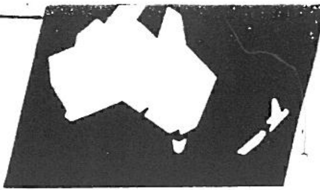

AUSTRALASIAN EPIDEMIOLOGICAL ASSOCIATION

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Treasurer: H.S. Mitchell, Melbourne, Vic.
Ph. (03) 62 0621, Ext 2606.
Fax (03) 624 039

RR:nb

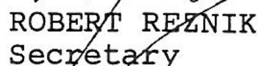
1st June, 1987

Dr. Graham Giles
Cancer Epidemiology Centre
1 Rathdowne Street
CARLTON SOUTH VIC 3053

Dear Graham,

I enclose with this letter a draft position paper of the Australasian Epidemiological Association on Mass Mammographic Screening. This was prepared at the request of the executive by Dr. Heather Mitchell. It has been reviewed by Dr. Bruce Armstrong. There are a number of recommendations made in this document and as you have a direct interest in the area, I would be pleased to receive your specific and detailed comments, criticisms and suggestions on how the document could be improved or modified. It will also be circulated to all AEA members in our first mail-out in about a fortnight, but I am taking this opportunity to ask you for prior suggestions before the document is sent out to all members.

Yours sincerely,



ROBERT REZNIK
Secretary

DRAFT POSITION PAPER OF THE AUSTRALASIAN EPIDEMIOLOGICAL ASSOCIATION ON MASS MAMMOGRAPHIC SCREENING

1. INTRODUCTION

2. IMPACT OF MAMMOGRAPHY ON MORTALITY RATES FOR BREAST CANCER

   2.1 COMPLIANCE BY WOMEN IN THE TARGET AGE GROUP

   2.2 QUALITY CONTROL IN SCREENING MAMMOGRAPHY

   2.3 MANAGEMENT OF WOMEN WITH ABNORMAL MAMMOGRAMS

3. RECOMMENDATIONS

1. INTRODUCTION

Two large randomised controlled trials performed in Sweden and New York have shown a 30% reduction in mortality from breast cancers in women whose malignancies were detected by mammographic screening. The reduction in mortality correlated with the ability of the x-ray to detect early stage tumours. The benefit persisted for 10-14 years after diagnosis and was observed in women over 50 years of age in both studies. For women 40-49 years of age in the USA study a reduction in mortality in the screened group similar to that seen in women 50-69 years appeared only after 14 years of follow-up. No evidence of a similar benefit in those 40-49 years of age has yet been reported from the Swedish study but so far follow-up only to 7 years has been documented.

While a number of countries are moving towards population-wide screening, only pilot studies of the feasibility of mass population mammographic screening in Australia are now being contemplated. No decision as to screening for all Australian women has yet been taken. Private radiologists however are already offering screening mammography to self selected women, with the women bearing the cost of the x-ray.

The Health Insurance Commission pays Medicare benefits for mammography under the following conditions:

1. Where the woman is referred with a specific request for this procedure.

   AND

2. Where there is reason to suspect the presence of malignancy because of a past occurrence of breast malignancy in the patient or in members of the patient's family.

   OR

   Where symptoms or an indication of malignancy were found on an examination of the patient by a medical practitioner.

Thus the current rules limit the rebate to the use of mammography as a diagnostic test or to women who are perceived to be at high risk of breast cancer because of a personal past history or a family history of breast cancer. Referral by a medical practitioner is compulsory, and thus self selected women who present to a screening centre and are subsequently found to fulfil condition 2 are ineligible for a rebate.

or women who request a referral from their G.P

While these rules may seem unnecessarily restrictive in the light of the overseas studies, they relate to the present position in Australia where the commonly used mammographic techniques are those appropriate to diagnosis in women who have already manifest signs or symptoms which could relate to breast cancer rather than the screening of asymptomatic women. If mass screening of asymptomatic women in the population were to be undertaken with the aim of achieving a comparable reduction in mortality to that observed in the overseas studies, then a number of important issues must be addressed.

2. IMPACT OF MAMMOGRAPHY ON MORTALITY RATES FOR BREAST CANCER

The impact of mammography on mortality rates from breast cancer is directly proportional to:

1. Compliance by women in the target age group. (ie. the proportion of women in the target age group who agree to enter a program and be repeatedly screened at defined intervals).

2. The accuracy of the x-ray reports.

3. The acceptance of ideal management by women of lesions detected. — ?

2.1 COMPLIANCE BY WOMEN IN THE TARGET AGE GROUP

The Swedish study achieved good rates of compliance and was able to screen a large proportion of the target population by using a formal system of "call and recall" incorporating personal invitations based on a list of women in the target population. The alternative to this formal arrangement is "self selected" screening where the woman herself has to make the approach.

Self selected screening is not ideal for women over 50 years of age, the age group for which the test has proven efficacy. There is substantial evidence that the Pap smear program (the only mass screening program for cancer in current use in Australia) has low use rates by women in this age range. Women aged less than 50 years are more likely to self-select for screening, and this is the age group where mammography has no proven efficacy.

If for example a self-selected service were to have as its target age group women 40-70 years of age (and this is proposed by a Melbourne group), then 38% of the targeted age group would be from the age group 40-49 years; with the higher compliance from this younger age group it is likely that for 50% of all women having the test, it would be of no proven value.

Secondly, self-selected mammographic screening is dependant on a woman's ability to pay for the test. This system will disadvantage women from lower socio-economic groups.

Thirdly, there is concern over the frequency with which women will elect to use self-selected screening programs. Some women with a preoccupation with cancer may present for mammography unnecessarily frequently, and therefore at unnecessary cost. Conversely other women may be screened only infrequently and these women will miss much of the potential benefit. It is emphasized again that the impact on breast cancer death rates is directly proportional to the number of women who are repeatedly screened at defined intervals.

Finally good rates of participation by women will be assisted by education campaigns that convince each woman that having the test regularly is in her own interest. These campaigns should be carefully designed and should avoid utilising hard sell tactics or disseminating inaccurate information.

2.2 QUALITY CONTROL IN SCREENING MAMMOGRAPHY

There needs to be an appreciation by those involved in mass screening that their responsibility extends beyond the mere issuing of a report for each woman. While this is the normal practice for pathology and radiology services dealing with patients with symptomatic or declared disease, it is inadequate for mass screening. The importance of quality assurance in tests which rely on human interpretation cannot be overemphasized, particularly when the test is being applied to a large number of asymptomatic people.

While accepting that human error is inevitable, its level should be continuously monitored and minimised by all feasible means. With respect to mammography the following should be the minimum:

1. Regular review of randomly selected films on which a normal report was issued to ensure repeatability of diagnosis and adequacy of film quality.

2. Matching of radiological reports with any subsequent pathology reports to ensure that the best standards of predictability are achieved.

3. Linkage of screening records to the records of the State Cancer Registries to detect breast cancers that may have been missed by screening.

Sensitivity analysis.

2.3 MANAGEMENT OF WOMEN WITH ABNORMAL MAMMOGRAMS

Meticulous followup of women with abnormal films is essential and should be based on a computerised system designed to minimise the chance that a woman will not be told that her x-ray was abnormal or that she may fail to attend for or receive appropriate investigations.

As the overseas studies have indicated that around 5% of women will have an abnormal film on an initial screening, it is vital that these women are managed using maximum skill so as to minimise the unnecessary treatment of women who eventually turn out not to have breast cancer. It should be remembered that while 5% of women may need further investigations, the annual incidence rate for breast cancer in women aged 50-74 years in Australia is 1 in 573 women.

While in clinics accepting self-selected women, the woman will have to bear the cost of the initial mammography, any further investigations will involve additional and possibly considerable expense to taxpayers through Medicare rebates. These subsequent investigations may include any or all of the following:

- repeat mammography
- ultrasound of the breast
- referral to a specialist surgeon
- closed biopsy costs:
  fine needle aspiration procedure
  cytology report of aspirated material
  return visit to specialist for results
- needle or other localisation of impalpable lumps under radiological control
- open biopsy costs:
  2-3 days hospitalisation
  surgeon's fees
  anaethetist's fees including a pre-operative visit
  theatre fees
  pathology fees
  preoperative blood tests if mastectomy is contemplated

It is stressed that not all women with an abnormal mammogram will have all of these tests. However it should always be remembered that these will be iatrogenic tests when a mammography report is falsely positive. In addition to their considerable financial cost they will also result in considerable emotional costs to the

women who for a period of time at least will believe that they have cancer. This has the potential to bring a screening program into disrepute and affect compliance rates.

The management of women with abnormal mammograms should be in specially designed clinics staffed by a range of experts with the necessary skills. It should not be left to general practitioners or general surgeons working in isolation. The valuable opportunity to study the natural history of a variety of abnormal breast conditions and refine our management techniques for early stage malignancy that such clinics present should not be overlooked.

The potential "winners" from mass mammography programs are those women who are correctly reassured that they do not have breast cancer (the true negatives) and those women who are diagnosed as having early stage breast cancer and who accept and receive appropriate management such that their survival status is altered (some of the true positives). The potential "losers" are women who are falsely reassured that they do not have breast cancer (the false negatives), women who are initially suspected as having breast cancer but who on further investigations are considered clear (the false positives) and women with advanced breast cancer whose date of diagnosis is advanced but whose outcome is not altered (the remainder of the true positives). The other group of potential losers are those Australians who suffer because of diversion of the limited resources of the health budget to a program where not all of the money expended can have a direct positive benefit on health.

RECOMMENDATIONS

1. That carefully designed pilot programmes for mass mammographic screening of women should be urgently carried out. These programmes should be coordinated nationally so as to obtain maximum value from the data collected.

2. That the private screening of self-selected women should not attract a Medicare rebate.

3. That the Commonwealth Department of Health support the introduction of mass mammographic screening only if the following conditions can be met:

   (a) an updatable list of women in the target population is available and satisfactory methods for its use in reaching women are devised.

   (b) compliance by women is considered to be likely to be satisfactory based on data from the pilot studies

   (c) a cost-efficient program can be designed

   (d) adequate staff and resources are available, including support clinics for the management of women with abnormal films

   (e) quality assurance procedures are in operation in all centres reporting on films

   (f) monitoring and evaluation of the program is carried out, including research on the issues of screening, diagnosis and management that remain to be resolved.

Recd: 27/5

Newcastle Mater Misericordiae Hospital

WARATAH
N.S.W. 2298
AUSTRALIA

(049) 67 9321

Professor John F. Forbes,
Professor in Surgical Oncology,
Director, Oncology Unit.

21st May, 1987

Professor Emeritus R.R.H. Lovell,
Executive Secretary,
Victorian Co-operative Oncology Group,
Anti-Cancer Council of Victoria,
Keogh House,
1 Rathdowne Street,
CARLTON SOUTH.
VICTORIA. 3053

Fri Sept 4

Dear Dick,

Thank you very much for your letter concerning Laslo Taber's visit.

I think that the suggestion is excellent and Ian Russell had also made a similar suggestion.

Dr. Taber would certainly be able to visit at the Council at 5 o'clock prior to a 5.30 lecture on "Mammography for Clinicians".

For your information I have enclosed his preliminary programme outline, and will see that you receive a copy in more detail as that becomes possible.

You will note that we have now been able to arrange a second course for Taber in Sydney, as the response to the Melbourne course sponsered jointly by the University of Melbourne Post Graduate Continuing Education Committee and the College of Radiologists has been quite overwhelming.

With very kind regards.

Yours sincerely,

JOHN F. FORBES

c.c. Mr. Ian Russell, Chairman, Breast Study Committee

Enc.

ATTACHMENT

PROGRAMME OUTLINE

Dr. Laslo Tabar,
Australia,
September, 1987

Arrive Melbourne approximately August/September 1.

September 3 - 5	University of Melbourne/Royal Australia College of Radiologists Course.
September 6 - 8	Consultant and visit to Breast Check Programme in Melbourne.
September 7	5 pm visit to Anti-Cancer Council of Victoria to meet with Dr. Nigel Gray, Professor Lovell, Mr. Russell and colleagues. 4.30 5.30 pm lecture "Mammography for Clinicians".
September 10 - 12	Sydney Oncology Course/Royal Australian College of Radiologists (Dr. Peter Wilson arranging).
September 13 - 18	Thredbo COSA ANZ Breast Cancer Trial Group mid year meeting and Medical Oncology Group COSA meeting. -
September 19	Depart Australia.

This programme is a draft, but as you all see it is going to be difficult to fit in visits to any additional cities during this visit as Dr. Tabar must be back in Sweden by Monday September 21.

- Sun evening keynote address
- major symposium screening

2 lectures

mini consensus

Commonwealth Department of
Veterans' Affairs

Repatriation General Hospital Heidelberg

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Facsimile: (03) 49 02 541
Contact
Reference JZ:sk

Telephone 490 2771

Private Bag No. 1
Heidelberg West
VIC 3081

Telephone: (03) 490 2111

23 February 1987

Mr Peter Hart
Austin Private Consulting Suite
226 Burgundy Road
HEIDELBERG 3084

Dear Peter

At the recent meeting of the Victorian Co-operative Oncology Group that I attended there was some discussion about screening projects for breast cancer. According to Nigel Gray it appears that the Federal government is particularly keen on mammography as a screening program and in fact has requested that three pilot projects rather than one be put forward from Victoria. The Anti Cancer Council is in the process of appointing a Project Officer who will assist in the development of appropriate protocols for screening women with breast cancer. Unfortunately, because of the timing of the next budget, only the Essendon/Royal Melbourne demonstration project will be submitted in any detail for approval. However, Nigel Gray suggested that several other pilot projects for which skeleton plans had been prepared out would also be presented.

In view of our recent discussions and the requirement that three screening programmes be developed in Victoria I wondered whether you would be interested in developing a proposal from the Austin/Repatriation. I still feel intuitively that the idea of screening women presenting to Community Health Centres offers an unusual twist which may favour our pilot programme. However, it is clearly not intended that quality of care be compromised in establishing such a project. I look forward to discussing this further with you.

Best regards.

Yours sincerely

Dr John Zalcberg
Director, Medical Oncology

CC Professor J McNeil
Alfred Hospital
Commercial Road
PRAHRAN 3181

Director: Dr Nigel Gray A.M. MB. BS. FRACP. FRACMA

Anti-Cancer Council of Vic

From R Lovell
6/5

May 5, 1987

COPY

The Hon. David White
Minister for Health
Department of Health

Dear Minister,

I am writing to follow up our discussions of Tuesday March 31 on the topic of mammography.

At that time you requested us to present proposals dealing with -

(i) the membership of our proposed breast cancer screening advisory committee

(ii) the terms of reference.

We have put considerable thought into these and I attach, for discussion with you, the two draft documents we have prepared. These are self explanatory. You will note that the terms of reference set up a single committee to take the major role in development and coordination of mammographic screening in Victoria. The committee would delegate off (under supervision) quite quickly, some very important but cost free exercises. Examples are -

1. Getting the radiologists to define standards for interpretations of mammograms.

2. Getting the pathologists to define their standard criteria and the ways of reporting.

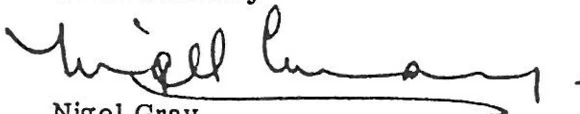
3. Contributing to national discussions about what sort of data should be collected.

4. Working on the establishment of a register of the population at risk (the Commonwealth Electoral Commission has already agreed to give us the electoral register for this purpose)

5. Working with the medical community to develop guidelines for the management of patients detected by the somewhat irregular and random mammography (also irregular in quality) which is currently occurring in Victoria and will continue until the pilot projects are complete and screening is (or is not) introduced.

These are merely examples of the work which needs to be started on as soon as possible.

Yours sincerely



Nigel Gray
Director

Encl: terms of ref; membership.

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Facsimile: (03) 663 3412 Telex: VCCG AA 34158

State Mammographic Screening Advisory Committee

draft terms of reference

1. To advise the Minister of Health on the development and coordination of mammographic screening in Victoria, including -

   (i) the design, execution and evaluation of pilot projects

   (ii) the definition of standards for the performance and interpretation of mammograms, and the standardisation of reporting

   (iii) the standardisation of the descriptions of pathological findings in lesions detected by mammography

   (iv) the criteria which should be met by all centres conducting mammographic screening.

2. To advise the Minister of Health on steps needing to be taken to monitor the effectiveness and efficiency of mammographic screening in Victoria.

3. To produce and keep under review guidelines on the management of patients with abnormalities detected on mammographic screening, and to promote their management under standard protocols for treatment, including clinical trials.

4. To establish and maintain liaison with other bodies in Victoria and elsewhere with interests in this field.

Aegis

The committee should be under the aegis of the Anti-Cancer Council of Victoria, and would properly be so under the Cancer Act. This, rather than the aegis of the Minister or Health Department is advocated because its Terms of Reference extend beyond advice to the Minister

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Director: Dr Nigel Gray A.M. MB, BS, FRACP, FRACMA

Anti-Cancer Council of Victoria

40-324

State Mammographic Screening Advisory Committee

proposed membership

The Director of the Anti-Cancer Council of Victoria (Dr Nigel Gray)	Chairperson
The Executive Secretary of the Victorian Cooperative Oncology Group of the Anti-Cancer Council (Professor Emeritus Richard Lovell	Executive Secretary

A nominee of the Breast Study Committee of the ACCV

An epidemiologist

A person experienced in behavioural research

A person experienced in public education in health

A nominee of the Royal Australasian College of Surgeons

A nominee of the Royal Australasian College of Radiologists

Three nominees of the Minister of Health, including two persons concerned with women's health issues.

The committee shall have power to co-opt additional members. (It is anticipated that the heads of pilot projects will be co-opted).

Alternates shall be nominated by the Committee to act in the places of members unable to attend a meeting.

Their term of appointment shall be five years in the first instance.

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