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AUSTRALIAN CANCER SOCIETY INC.

MINUTES OF THE MEETING OF THE NATIONAL BREAST STUDY COMMITTEE HELD IN THE CONFERENCE ROOM, 3RD FLOOR, 500 GEORGE STREET, SYDNEY ON WEDNESDAY 5 AUGUST 1987.

Present:
Mr I. Russell (Chairman)
Dr M.J. Byrne
Mr C. Furnival
Ms J. Hall
Professor A. Langlands
Dr H. Mitchell
Dr S. Redman
Dr R. Reed
Mr S. Renwick
Dr I. Ring
Mrs D. Shugg
Professor M. Tattersall

Present by Invitation:

Dr A. Adams	Chairman, AHMAC Sub-Committee on Breast & Cervical Cancer Screening
Ms R. Hall	Assistant to Dr Adams
Dr M. Fett	Australian Institute of Health
Ms S. Hurley	Anti-Cancer Council of Victoria

Secretary
Mr L. Wright

The meeting was opened at 10.15 am.

1. Welcome and Apologies:

The Chairman welcomed all the committee members and extended a welcome to those present by invitation. He said that Dr Mitchell and Dr Reed had been delayed in Melbourne by aircraft problems and would join the meeting when they could.

2. Minutes of the Previous Meeting:

The minutes of the meeting held on 24 April 1987, previously circulated, were tabled, together with a letter from Professor McCaffrey objecting to the report on the activities at the Royal Women's Hospital Brisbane.

Dr Ring supported the objections raised by Professor McCaffrey and Mr Furnival agreed that they misrepresented the position. The introduction to sub paragraph 3.11 was corrected.

3. AHMAC Sub-Committee on Breast and Cervical Cancer Screening:

The Chairman informed the meeting that Dr Adams had limited time and invited him to brief the meeting on the intended activities of the AHMAC Sub-Committee.

Dr Adams said that his sub-committee had been set up to develop national strategies, evaluate screening techniques and recommend funding arrangements for breast cancer screening, and now cervical cancer screening was also included in the brief. He said working parties would be set up to cover each category of disease.

The AHMAC committees would look to expert groups such as the ACS NBSC for guidance on the medical issues and would be mainly concerned with developing evaluation criteria, evaluating different programs and evaluating funding recommendations. His sub-committee would meet again in October. He also added that in NSW a number of screening projects would be seeking Commonwealth funding and would require evaluation.

The meeting then discussed with Dr Adams a number of issues arising from his briefing and the following guidance was given.

In response to a question from Mr Furnival regarding the time frame for lodging bids for financial support for projects or project evaluation Dr Adams said that such bids should be made through State offices to the Commonwealth not to AHMAC.

Dr Adams, in response to Professor Tattersall, confirmed that the AHMAC sub-committee would rely on the guidance of the NBSC on the future of programs as the committee had no desire to duplicate work already being done.

Dr Ring asked whether the evaluation process would aim to identify the best screening program or to establish whether each program achieved an acceptable standard. Dr Adams replied that both aims were complementary and there would be 'quality assurance' as well as guidance for future programs on evaluation criteria.

Ms Hall asked if the sub-committee would set a timetable for the introduction of mass screening. Dr Adams said there was no timetable and this would have to await examination of the costs involved.

Professor Langlands said that it was already proven that mammography reduces mortality and it was not a matter of proving this again but deciding the best way of providing this service. Concurrent with this evaluation was the need to begin training radiographers so that the operatives would be available to provide the service when the decision on its form was taken.

Dr Ring said that project directors were anxious to know how much Government money would be provided and when. Dr Adams said that the sub-committee comprising Armstrong, Newby, Hall, Cranny, Russell, Harvey plus a couple more would meet in October to decide this.

There was a general discussion on the role of the private sector in providing diagnostic services. Mr. Furnival said the Wesley clinic should be evaluated against the Royal Womens Hospital (Brisbane) clinic and would be seeking funding. There was agreement that as the Australian health care system had duality the private sector role must be addressed despite fears that entrepreneurs could exploit the opportunity to over-service.

The basis of screening - 'population' or 'self-screening' - was also discussed at some length with the option of employer based programs also suggested.

Dr. Adams said that AHMAC had no preconceptions and would look at any reasonable proposal. He agreed to provide minutes of the AHMAC sub-committees to the NBSC to maintain the flow of information and liaison between the committees.

Dr. Adams and Ms Hall left the meeting (10.50 am).

Mr. Russell reviewed the proceedings at the AHMAC meeting.

Drs. Mitchell and Reed arrived (10.55 am).

4. Meeting of Project Directors:

The Chairman tabled the report of the meeting held on 19 June and asked that the recommendations be considered.

Professor Tattersall said that the Sydney project was to start in October and unless the data to be collected was agreed quickly it might not be possible to establish a standard report to aid evaluation. Dr. Ring said that a logical sequence had to be followed with the NBSC identifying the questions and AHMAC developing the evaluation criteria. He said all of the intended projects should be identified and all directors brought together to co-ordinate procedures. This was time consuming and the Sydney project might have to begin having agreed on all that can be decided at that time and make adjustments later if necessary.

Mr. Renwick commented that the Sydney project would not record 'risk factors' for all but some cohorts would be selected for deeper data research. Mr. Russell said that while individual projects would wish to collect data specific to their particular projects there was a need to establish the core data to be recorded by all projects. Dr. Mitchell noted that government funds would be needed to provide computer hardware, data base and collection facilities.

Professor Langlands said that an estimate of costs for the 'work up' of abnormalities detected was needed. Dr. Mitchell said that estimates of this ranged from $40m-$80m but the Commonwealth estimates were grossly less than this. The meeting discussed the difficulty of establishing cost when a number of variables e.g. hospital costs, were present, but, it was agreed that costs would need to be contained.

4.1 Core Data Base

Mr. Russell said that it was essential to agree on the data to be collected and the format for collection.

It was agreed that Dr. Ring should convene a meeting of representatives of the Sydney (Rachel Forster), Victorian, Western Australian and Queensland projects. Included in the group should be Dr. Fett (A.I.H.), Ms. Hall and Ms. Hurley. The organisers of proposed projects at Newcastle and Westmead Hospital should be invited to send observers to the meeting. The forms prepared by the Sydney project are to be pre-circulated and used as the basis for discussion. The ACS will meet the costs of the meeting.

4.2 Standards of Mammography and Reporting

It was agreed to form a sub-committee of radiologists from the Victorian, Western Australian, Rachel Forster (Sydney) and Royal Womens (Brisbane) projects. Professor Hare would be invited to act as convenor of the sub-committee which should include Dr Irwig. The sub-committee is to advise the NBSC on technology, reporting and quality control of mammography for breast screening to include such matters as

techniques
standardisation of reporting
methods of assessment
data to be collected
comparison between projects

4.3 Pathology Sub-Committee

The meeting agreed to establish a pathology sub-committee and there was discussion on how to standardise reports from the private sector and classification of tumours of less than 5mm.

Dr. Reed agreed to act as convenor and project directors have been invited to nominate their representatives.

4.4 Management of Detected Lesions

A paper prepared by Mr. Furnival was circulated at the meeting and was discussed at length. ATTACHMENT 1

A major concern was the need to counsel and follow up patients with a positive result (although cost factors were seen to be limiting) as well as counselling patients with a negative "screen" who later developed breast cancer. Professor Tattersall suggested that a video be made to explain the meaning of positive and negative results.

4.5 Population Based Screening

The use of population based versus non-population based screening was debated with a spread of opinion on the merits and cost factors of the alternatives. This was complicated by the absence of reliable Australian data. Other alternatives were mentioned, such as industrial or employer based programs. Professor Tattersall said that 'self selection' screening was helpful in planning a national strategy provided there was adequate follow-up, however, non-population based screening was hard to evaluate.

4.6 Economic Evaluation

The role of the NBSC in economic evaluation vis-a-vis AHMAC was queried. It was decided to seek the guidance of the AHMAC Sub-committee on economic issues identified by the NBSC.

4.7 NBSC Role

Dr. Mitchell asked what role the NBSC would have once the pilot mammography projects were completed.

Mr. Russell replied that the committee had the responsibility of advising the ACS on all matters relating to Breast disease but Screening was seen to be the most important current issue and other matters had been put to one side at the moment.

Dr. Ring said that training was a critical issue and should be discussed. Professor Langlands agreed and said that the implications for training, staffing and equipping detection centres, whatever format was accepted, should be taken up now and the RACR involved. It was decided to place these issues on the agenda for the next meeting.

5. Register of Abnormal Mammograms:

The responses from committee members were noted. Dr. Furnival commented that the setting up of the screening projects would reduce the need for a central registry for abnormal mammograms.

It was agreed to refer the responses to the Mammography sub-committee.

6. In-Situ Tumours:

The matter of in-situ tumours is to be placed on the next agenda.

7. BCSS Pamphlets:

Mrs Shugg thanked the committee for the individual comments she had received on the booklet 'Living with the Loss of a Breast' and the draft lumpectomy booklet. She commented that a better name was needed for the booklet on lumpectomy.

The issue of lymphodoema was discussed, particularly whether it was preventable and the need to educate nurses about protecting the arm at risk. It was noted that the Queensland Cancer Fund was organizing a meeting on Lymphodoema on 3 October.

8. Membership of Committee:

The Chairman noted that the committee still lacked a representative from South Australia and a GP. Professor Radford had been unable to accept an invitation to join and another nominee would be sought.

He also noted that although mammographic screening was the priority issue there was no Radiologist on the committee and he suggested that this be corrected by inviting the Chairman of the Mammography Sub-committee of the RACR, Professor W. Hare, to join. The committee concurred with this recommendation.

9. Next Meeting:

The suggested date/place for the next meeting is 23 October, Sydney.

The meeting was closed at 2.50 pm.

Chairman.

AUSTRALIAN CANCER SOCIETY INC.

1. THERE WILL BE A MEETING OF THE NATIONAL BREAST STUDY COMMITTEE HEL IN THE LARGE CONFERENCE ROOM, 3RD FLOOR, 500 GEORGE STREET, SYDNEY ON WEDNESDAY 5 AUGUST 1987 COMMENCING AT 10.00AM.

2. Air ticket for air travel is attached where appropriate. Claims for incidental expenditure should be made at the meeting.

3. Luncheon and refreshments will be provided. It is anticipated that the meeting will close by 3.00pm.

14 July 1987

L.A. Wright
Executive Director.

A G E N D A

1. Apologies & Welcome:

2. Minutes of the Previous Meeting:

The minutes of the meeting held on 24 April 1987 will be tabled for confirmation. Copy attached.

ATTACHMENT 1/1.

Letter from Professor McCaffrey - Copy attached.

ATTACHMENT 1/2.

3. Minutes of Project Directors:

There was a meeting of the Directors of the mammography projects held in Sydney on 19 June 1987.

Notes on the meeting are attached.

ATTACHMENT 2.

Matters for discussion arising from the meeting are

3.1. Current status of pilot projects
3.2. Working parties
  3.2.1. Data collection and evaluation
  3.2.2. Mammography
  3.2.3. Pathology
  3.2.4. Economic evaluation

4. Mammography Screening Sub-Committee of AHMAC:

The Australian Health Ministers' Advisory Council (AHMAC) has set up a sub-committee on breast cancer screening under the chairmanship of Dr Tony Adams. Mr Ian Russell was nominated as the ACS representative on the sub-committee. See letter attached.

ATTACHMENT 3.

5. Register of Abnormal Mammograms:

Correspondence from committee members is attached as under

Ms S. Redman	ATTACHMENT 4/1.
Prof M. Tattersall	ATTACHMENT 4/2.
Prof A. Langlands	ATTACHMENT 4/3.
Dr I. Ring	ATTACHMENT 4/4.
Dr C. Furnival	ATTACHMENT 4/5.

6. Breast Cancer Support Service:

At the last meeting Mrs Shugg sought opinions on an information sheet on lumpectomy, alternative description of less-than-mastectomy, the incidence of lymphodema and the suitability of the pamphlet 'Living With the Loss of a Breast'.

These questions were referred to members in writing and will be discussed at the meeting.

7. Other Business:

7.1. Date of next meeting.

AUSTRALIAN CANCER SOCIETY INC.

MINUTES OF THE INAUGURAL MEETING OF THE NATIONAL BREAST STUDY COMMITTEE HELD IN THE CONFERENCE ROOM, ANTI CANCER COUNCIL OF VICTORIA, 1 RATHDOWNE STREET, CARLTON, VICTORIA ON FRIDAY 24 APRIL 1987.

Present:
Mr I. Russell (Chairman)
Dr M.J. Byrne
Mr C. Furnival
Ms J. Hall
Professor A. Langlands
Dr H. Mitchell
Ms S. Redman
Dr R. Reed
Mr S. Renwick
Dr I. Ring
Mrs D. Shugg (from 12.35pm)
Professor M. Tattersall (from 1.45pm)
Mr L. Wright (Secretary)

Also Present:
Mr W. Fleming
Professor Hare.

The meeting was opened at 11.00am.

1. Welcome:

Mr Russell thanked the members for agreeing to join the committee and noted that Sister Shugg and Professor Tattersall would arrive later. He said that the committee had the potential to be of great value in establishing policies in the treatment of breast cancer and should be therefore very satisfying for the committee members.

He said that the agenda for the meeting dealt mainly with screening and he foreshadowed the use of small working groups based on committee members to examine specific issues.

He then invited Mr Fleming, Chairman of the ACS Patient Affairs Committee to give the background to the appointment of the committee.

2. Introduction:

Mr Fleming outlined the new policy of the ACS to move from providing a forum for the State cancer bodies to providing national policy guidance to its members and outside bodies.

He said that the role of the Breast Study Committee had been set by two broadly representative seminars and it had been constituted to provide coverage of all the professional areas involved as well as providing representation for all the major bodies involved. He stated that the committee would have to earn acceptance through the relevance and quality of its work.

He referred to the ACS press release on mammography and commented that the media has been totally disinterested.

He reviewed the activity of the Better Health Commission (BHC), Australian Health Ministers Advisory Committee (AHMAC) the NH & MRC Working Party and the potential for conflict and confusion between the interested organizations. He said that the ACS had accepted a grant from the Commonwealth Government to develop a National Cancer Control Plan (NCCP) and said that the ACS had offered to assume the role of principal adviser to the Commonwealth Government on cancer matters. This role would be funded through the resources of the State cancer bodies and expressed through the work of sponsored expert groups such as the NBSC.

He referred members to the attachment detailing the responsibilities and interactions in breast cancer.

Mr Fleming said that the NBSC was asked as one of its first tasks to provide guidance for the breast cancer aspects of the NCCP by answering three questions, as under

1. Should Australian governments introduce organized screening by mammography, in contrast to non-organized or passive screening?

2. What would be the estimated costs per year of life gained with these contrasting systems of mammography?

3. Organized implies a system of call and recall, quality control and valuation. How could such a system best be developed in collaboration with the medical and other health professions?

He said that pilot projects to examine alternatives could expect to receive Government funding particularly with an election to be held shortly.

He asked that the responses to the questions be supplied for inclusion in an interim report to be prepared in late June 1987..

3. Breast Screening:

3.1. Existing and Foreshadowed Projects

Four papers, pre circulated, were tabled and discussed. Copies of the papers are attached, as under

Queensland - Dr Ring	ATTACHMENT 1/1
Western Australia - Dr Byrne	ATTACHMENT 1/2
New South Wales - Dr Renwick	ATTACHMENT 1/3
Victoria - Mr Russell	ATTACHMENT 1/4

Discussion points emerged as under

3.1.1. Queensland

Locating the screening clinic in a public hospital presented cost problems. Most women screened had symptoms or signs of breast disease.

The Queensland group considered that mass screening was not viable but screening selected groups could be. The questions to be answered were age groups, screening intervals, whether physical examination should be part of the screening process and whether it was necessary for film to be read by radiologists.

The Queensland project used hospital equipment under hospital rules and to increase throughput dedicated equipment and night and weekend screening would be needed.

Positive findings were referred to the patient's general practitioner or into the hospital system.

Mr Furnival informed the meeting that a Breast Screening Clinic was being introduced at the Wesley Hospital which would accept private fee paying patients only. Where conditions were met Medicare rebates would be claimed but the clinic was intended to provide a service. A fee of $30 would be charged which would 'at best' allow the clinic to break even on costs.

3.1.2. Western Australia

Dr Byrne said the service would be separate from teaching hospitals and the target populations would be identified from the Electoral Roll and approached by mail.

The adequacy of the Electoral Roll as a source of accurate and complete information was questioned.

3.1.3. New South Wales

Dr Renwick said that the problem of establishing the target group would be met by reference to the Electoral Roll although it was hoped that access would be given to census material.

3.1.4. Victoria

Mr Russell said the pilot project would be set up in the Essendon Hospital. The community being targetted had large ethnic groups and these would present particular problems for compliance. An education campaign to overcome fear of radiation exposure might be needed.

3.2. Issues in Breast Screening

3.2.1. Dr Mitchell tabled a discussion paper on Issues in Breast Cancer Screening.

Copy attached - **ATTACHMENT 2/1**

In summarising her paper Dr Mitchell said that Australia should follow overseas practice and screen the 50-64 age group where benefit had been demonstrated. She stressed the importance of population screening and said that it should start at age 50 on a 3 year interval with more frequent screening for high risk groups.

Mr Renwick said that NSW were beginning at age 45. Professor Langlands questioned the use of an age basis, when menopause seemed to be the critical factor.

Dr Mitchell commented that there was no evidence that BSE was of value as it did not alter the risk profile.

Dr Ring said that it was the feasibility rather than the desirability of population screening which was difficult. Queensland was rescreening on a two year basis but he conceded that a three year interval was probably more appropriate in older women. Mr Fleming said that from an educational aspect it would be easier to set a specific age birthday for women to present for a 'once only' screen.

3.2.2. Professor Hare tabled a discussion paper on Mammography.

Copy attached - ATTACHMENT 2/2

Professor Hare first commented on the Interactions paper presented by Mr Fleming and said that the RACR Mammography Sub-Committee should be included on the table.

Professor Hare stressed the importance of a central recording system to enter all patients screened whether at private or public clinics. He reviewed the advantages of Xeromammography and film mammography, likely developments, the Swedish experience and the lessons it could offer. He commented that mobile clinics should have 'on board' processing to ensure that images were satisfactory before patients left and said that there was a real need to introduce standard reporting procedure. Dr Renwick said that if a standard report was to be introduced he would need it in 3/4 months for the introduction of the NSW service. Professor Hare said that he would urge Dr Frayne to complete his proposal by then.

There was discussion on who should read the films. The problem of boredom for doctors reading a succession of normal films was mentioned and this raised the possibility of preliminary reading being carried out by para professionals with abnormal films being referred to medical professionals.

Mr Furnival asked if the RACR would favour all screening being performed in Government funded screening clinics. Professor Hare said that the College would not be very happy about this solution but would accept it particularly if there was not to be a Medicare rebate available for screening.

There was discussion on the need to take two views initially and the conflict in recommendations of the Swedish model and the Forrest report.

Dr Reed commented that although collation of data centrally had obvious benefits there would be problems with confidentiality of patient records. It would have to be decided whether the radiographer or the referring GP should provide the information. Dr Mitchell agreed that privacy posed a problem.

3.2.3. Mr Furnival tabled and discussed a paper on Management of Identified Lesions.

Copy attached - ATTACHMENT 2/3

3.2.4. Dr Ring tabled a discussion paper on Evaluation of Breast Screening.

Copy attached - **ATTACHMENT 2/4**

4. NH & MRC Workshop on Public Health Research into Breast and Cervix Cancer:

A report of the recommendations arising from the Workshop were tabled.

It was envisaged that the recommendation to establish a national coordinating committee for breast cancer would be met by the existence of the NBSC. It was observed that the ACS could fulfil the role as adviser on policy but coordination of implementation was a matter for the States.

In response to a question from Professor Tattersall Dr Mitchell said that recommendations had been made on research topics and these had gone forward to the NH & MRC for funding.

5. Breast Cancer Support Service Coordinators Meeting:

After a brief discussion on lymphodema the committee members were asked to write direct to Sister Shugg to give her their views on the questions raised by the BCSS Coordinators and the suggested information pamphlet on lumpectomy.

The article in the New Scientist was discussed and although the committee was generally in agreement with the recommendations there was doubt about the data cited.

6. Other Business:

Professor Tattersall referred to an American video 'A Matter of Choice' which he said could be adopted for Australian use. He agreed to provide a copy for viewing to Mr Russell.

7. Summary of Discussions:

Mr Russell tabled a draft review of the matters discussed, opinions formed and recommendations to be made.

These are attached - **ATTACHMENT 3.**

8. Date of Next Meeting:

The proposed date of the next meeting will be advised by the Chairman.

ATTACHMENT 1/1

BREAST SCREENING CLINIC

ROYAL WOMENS HOSPITAL, BRISBANE

A Breast Screening Clinic was established by the Queensland Government at the Royal Women's Hospital in December - 1985, following a report from an Expert Committee.

The Committee accepted that screening of asymptomatic women over fifty years of age had been shown to lower mortality, and the aim of the Clinic was firstly to see if screening could be made affordable, and secondly to examine some of the practical issues about the operation of screening clinics.

The original aims of the Clinic, therefore, were:

- to determine the costs of breast screening;
- to determine the characteristics of women who do and do not present for screening;
- to compare the effectiveness of doctors and nurses in carrying out physical examination;
- to determine the role, if any, for ultrasound; and,
- to determine the number and characteristics of the cancers and other lesions detected, the biopsy rate, etc.

The Clinic screens women aged fifty years and over and/or who are at-risk because of a family history or previous breast disease. Patients come to the Clinic either by self-referral or a referral by a general practitioner. The Clinic is staffed by a Medical Practitioner, a Nurse, a Typist, a Radiographer and part-time Radiologists. Screening consists of a single oblique view and a physical examination. The routine rescreening interval is two years.

While it will be possible to examine the proportion of the population in the catchment area for the Clinic who are screened, no formal attempt is being made at this stage to achieve a given level of population coverage. This is for two reasons. Firstly, until it is shown that screening can be made affordable in a single Clinic, there is no question of attempting to cover an entire population. The second reason why the clinic does not attempt to achieve population coverage is that a very significant section of the population will probably be screened privately. Thus, while attempts will be made to encourage eligible women to be screened, some will choose to have screening performed in the private sector and some in the public sector, as is the pattern with other aspects of hospital and medical care. The feasability of assessing the combined coverage of public and private clinics is being investigated.

.../2

A major review of the operation of the Clinic is to be undertaken following the release of the Forrest Report. This review will cover:

- Age of women to be screened.
- The need for a physical examination.
- Rescreening interval.
- The number of views required.
- The staffing of the clinic.
- The role of a review clinic.

Ian Ring

8 April 1987

ATTACHMENT 1/2

Sir Charles Gairdner Hospital

The Queen Elizabeth II Medical Centre
Verdun St., Nedlands, Western Australia 6009
Telephone: (09) 389 3333 Telex: AA93446

Ext. 2648 MJB:gs

15 April 1987

Mr I. Russell
Chairman,
National Breast Study Committee
Anti-Cancer Council of Victoria
1 Rathdowne Street
CARLTON SOUTH VIC 3053

Dear Ian,

The report of the Working Party on Screening Mammography in Western Australia is not yet available. I have obtained from Professor B.K. Armstrong, who is the Chairman of the Working Party, a preliminary working paper of the Group.

The following is a brief summary:

Terms of Reference

The terms of reference were:

To consider and report to the Minister for Health regarding:

(i) The role of mammographic screening of well women in the reduction of illness and death from breast cancer in Western Australia.

Iii) An optimum programme for mammographic screening in Western Australia including consideration of community attitudes, costs and benefits, the practicalities of introducing and monitoring such a programme and research that should be undertaken in association with it.

(iii) The need for and role of public and professional education about screening mammography.

Incidence

Overall incidence

Breast cancer is the commonest cancer in Western Australian women after non-melanocytic skin cancer (on which accurate data are not available). Over the four years in which complete cancer registration data have been available (1982 to 1985) an average of 419 new cases of breast cancer were diagnosed each year (Hatton and Clarke-Hundley, 1984, 1985 and 1986; Hatton and Clarke-Hundley personal communication). In 1984, the crude incidence rate was 63.3 per 100,000 woman years in females of all ages and the age standardised incidence rate was 55.3 per 100,000 - a figure somewhat less than that in North America but similar to that in most Western European populations (Hatton and Clarke-Hundley, 1985; Waterhouse et al, 1982).

Outline of Optimal Programme for Mammographic Screening in W.A.

Envisages :

a) Two-view mammography.
b) Target population : females 50-74 years of age. Number in Western Australia in 1985 129,800.
c) Screening Interval: 2 years

Organization of the programme

Identification of target population will probably be based on Australian Electoral Commission roles but Medicare records would be preferred.

Location and staffing

It is envisaged that the screening will be undertaken by fixed units within the Perth Statistical Division and mobile units serving the population outside of this Division. Assuming that 1 fixed unit can screen about 7,500 women annually, six such units would be needed. It is envisaged that mobile screening units would be able to screen approximately 4,000 women per year and so 3 such units would be required. A central co-ordinating unit would be located with Central Film Reporting Service in Perth.

Cost

The estimated cost per screened woman is approximately $50. This includes the costs of any additional screening modalities, the cost generated by "positive" mammograms in women who prove not to have cancer and the costs of operating a call, recall, follow up and evaluation programme. It incorporates calculation of a reduction in cost due to those investigations for breast cancer which would in any case be undertaken if no screening programme were offered and also for the expected annual costs of breast cancer in treatment in target populations in the absence of mammographic screening.

Implementation

The programme would be initiated on a pilot basis with a single unit in the Perth Statistical Division and then subsequently a single mobile unit.

Yours sincerely,

Michael Byrne
MEDICAL ONCOLOGIST

ATTACHMENT 1/3

A PILOT MAMMOGRAPHIC SCREENING PROJECT INCORPORATING A MOBILE SCREENING UNIT BASED ON RACHEL FORSTER HOSPITAL BREAST CLINIC IN THE ROYAL PRINCE ALFRED HOSPITAL AND AREA HEALTH SERVICE UNDER THE AUSPICES OF THE UNIVERSITY OF SYDNEY CANCER SERVICES COMMITTEE

BACKGROUND

Breast cancer is the leading cancer causing female deaths in New South Wales, accounting for more than 750 deaths annually. Several international studies of mammographic screening of women over age 45 have demonstrated that in the setting of a controlled trial, this approach can reduce mortality from breast cancer by 30%. Moreover, identification of preclinical breast cancers by mammography means that less surgical treatment is necessary to control local disease, thus rendering treatment more acceptable.

Females over age 45 and under 70 years comprise approximately 12% of the total Australian population. International recommendations concerning the optimal frequency of mammographic screening are that this should be repeated every two to three years. The introduction of mammographic screening in this large population constitutes a significant logistic problem with substantial cost implications.

Breast cancer is diagnosed in one out of every 15 females in Australia, and the incidence appears to be increasing. While mammographic screening may reduce breast cancer death rates, further investigations to define high risk groups and to prevent breast cancer are clearly necessary. The establishment of a pilot mammographic screening project in the Royal Prince Alfred Hospital and Area Health Service with a total

population of 296,000 will:-

a) Identify how regular mammographic screening can be made available to Australian females over age 45.

(b) allow the development of a screened population in whom studies to identify high risk individuals can be mounted.

(c) allow new approaches in breast cancer diagnosis and prevention to be investigated.

(d) allow residents of other health areas to be included among the screened group during the second year.

PROPOSAL

1. To establish a mammographic screening service for women over 45 and under 70 years living in the Royal Prince Alfred Hospital and Area Health service with the goal of identifying early breast cancers. It is proposed to establish a mobile mammographic screening facility based on the Rachel Forster Hospital Breast Clinic so that the service can be made available to all residents in the Area. Rachel Forster Hospital has a well established breast clinic for the investigation and management of women with symptomatic breast diseases, and it has recently installed sophisticated mammographic equipment which is ideal for following up abnormal screening mammograms. Rachel Forster Hospital Breast Clinic is currently one of the few such specialised clinics in the public hospitals, and its existing multidisciplinary team of clinicians, radiologists, histo or cytopathologists will ensure that the costs of further investigation of individuals with abnormal screening mammograms will be kept to the minimum, consistent with optimal management. Moreover, Rachel Forster Hospital has the required film development and reading facilities and space to house

the records of all persons screened and to maintain a follow-up system with the intent of triennial screening.

2. To establish a register of all women over 45 living in the area with the intent of attempting an 80% or greater penetration of the target population for mammographic screening.

3. To establish a mobile mammographic screening service to visit major centres of population, initially in the immediate locality of the Royal Prince Alfred Hospital and Area Health Service. The goals of the mobile service are:

   : to increase the penetration of the screening service in the community.

   : to pilot the concept of mobile mammographic screening in the Australian community.

   : to establish links with other mammographic screening projects to ensure that expert screening and appropriate further management of women with abnormal mammograms are available to women living in New South Wales.

REVIEW OF POSSIBLE METHODS OF PROVIDING MAMMOGRAPHIC SCREENING TO WOMEN OVER AGE 45 IN NEW SOUTH WALES

An expensive option is to provide a medical benefit for breast cancer screening. This option has no real prospect of achieving either a major penetration of the population known to benefit from screening, nor the ability to quality control screening services or subsequent

breast cancer management. The existing schedule fee for bilateral mammography is $63, with a rebate of $53.55. In general this service involves three films of each breast, while the recommendations concerning screening of asymptomatic women are for one or two films of each breast. It is therefore possible that the rebate could be reduced to between $20-40.

In the population at large, females over age 45 and under 70 years comprise about 12% of the total, and thus in the RPAH area, the population for whom screening is recommended is approximately 36,000. This group should be screened every three years ie. 12,000/year, which according to the rebate proposed above would cost $240-480,000 annually. These calculations applied to the same fraction of total population of NSW females would add up to 15-20 times this figure.

The possibility of approving only certain radiology units/practices for screening may not be acceptable to the College of Radiologists, but its major benefits would be in quality control of service and in channelling appropriately individuals with abnormal mammograms to identified specialist groups for further management.

A third and the preferred option is to create a centralised coordinated screening service based on the proposed University Teaching Hospital alignment of cancer services now adopted by the New South Wales Department of Health.

DETAILED PROPOSAL

It is proposed to establish a purpose oriented mammographic screening service with centralised organisation and expert radiological capabilities, with a mobile mammographic screening unit visiting the surrounding community. Abnormal mammograms identified by the mobile unit will be appropriately further investigated in the centralised facility with its expert radiological, surgical and oncological expertise.

The central facility which will be developed at Rachel Forster Hospital will provide :-

(a) a new purpose oriented mammographic screening capability comprising a single machine, dark room, filing and reporting room;

(b) a detailed record system and individual contact service;

(c) a focal point for referring women with abnormal mammograms identified during screening for more detailed radiological and clinical studies.

Within the central facility, a single mammography screening machine working 16 hours per day five days per week and screening six females per hour by single view mammography can screen 500 females per week = 25,000 per year. Thus in one year, approximately two thirds the women in the RPAH Area Health Service aged 45-70 could be screened in the central facility. However in order to encourage the target population to attend for screening and to facilitate a high penetration of the target population, it is proposed to develop an outreach mobile service which would have as its base the central facility where all the screened films would be read, follow-up arranged and records kept. Such a service would require a second mammographic machine and an

appropriate vehicle. The initial goals of the mobile machine would be to visit areas of population in the RPAH and Area Health Service distant from Rachel Forster Hospital but later this service could be extended to cover adjacent health areas and link in with other mammographic screening projects as they become established. Initially links with the breast clinics of the other teaching hospitals within the University of Sydney Cancer Service would be established so that patients with abnormal mammograms identified by the mobile screening unit could be referred to their closest breast clinic for further investigations. It is essential however that central records are maintained until the pilot project is completed (minimum of two years).

The centralised screening service and a single mobile mammographic screening facility would cost the following in the first year :

Capital Costs

Purchase of 2 screening mammographic machines	=	$180,000
Purchase of appropriate vehicle	=	$100,000
Clerical equipment - film reading materials computerised records	=	$20,000

Recurring Costs

Radiographer staff (3)	=	$75,000
Filing clerks (2)	=	$40,000
Materials - x-ray film	=	$80,000
Project manager	=	$40,000
Radiologist staffing	=	$80,000
Part-time epidemiologist	=	$10,000

(First year Total recurring costs $150.000)

The identification of the target population and of those who have not attended for screening requires the services of a part time epidemiologist.

Evaluation of new methods of breast cancer detection, should be undertaken in the context of the mammographic screening service, but clearly identified as investigational. Such investigations might be linked to defined sub-sets of women presenting for mammography. It is an essential part of the screening project on which the hoped for survival gain is based that appropriate follow-up be provided for women identified as having mammographic abnormalities to avoid excessive, inadequate or inappropriate further investigations and management.

It is proposed that the mammographic screening service in the Royal Prince Alfred Hospital and Area Health Service should refer individuals with abnormal mammograms to the Rachel Forster Breast Clinic where high quality and sophisticated radiological, pathological and clinical expertise in breast disease is concentrated. Based on Swedish and United Kingdom data it is estimated that 50 abnormal mammograms will be identified per 1000 women screened. In the first year at least 1250 abnormals will be referred to the Rachel Forster Breast Clinic where three view mammogram, clinical examination ± fine needle aspiration will be performed. Real time ultrasound equipment is not currently available however, and the provision of this capability would enhance the clinics capacity to investigate abnormal screening mammograms. One fifth of the individuals will be referred subsequently for surgical biopsy, and 75 cancers will be found.

ie. screen 1000 women single view

→ 50 abnormals referred to Rachel Forster Hospital Breast Clinic for specialist assessment

→ 10 cases referred for biopsy (three cancers).

During the first year of operation of the screening service, an additional half day Breast Clinic at Rachel Forster Hospital will need to be established to cater for the 25 individuals per week being referred as a result of an abnormal screening mammogram. In the second year of screening a clinic staffed by two breast surgeons one day per week will be required and an additional radiological session.

In the first year $50,000 to establish the additional clinic will be required.

The costs in the second year will amount to :-

$80,000 for visiting medical officer sessions.

$12,000 for clerical/nursing assistance.

TRAINING OF RADIOGRAPHERS, AND RADIOLOGISTS

The Sydney Square Diagnostic Breast Clinic has offered to train staff in mammographic techniques and in reading mammography films. Dr. Tabar from Sweden who is recognised as the European expert in mammography will be in Australia during 1987, and it is hoped that he will visit the unit and give advice concerning the proposed pilot project.

SUPPORT

The Chairman and Chief Executive Officer of Royal Prince Alfred Hospital and Area Health Service, the Chief Executive Officer of the

Rachel Forster Hospital, together with the staff of the Rachel Forster Hospital and Royal Prince Alfred Hospital Breast Clinics strongly support this project. Members of the Breast Cancer Subcommittee of the Cancer Information Panel of the New South Wales State Cancer Council endorse the project, and Dr. Joan Croll of the Sydney Square Diagnostic Breast Clinc has indicated her willingness to train staff. The University of Sydney Cancer Services Committee will be briefed about this proposal at its first metting on December 5th, 1986.

M.H.N. Tattersall

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S. Morey,

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A PILOT PROJECT FOR MAMMOGRAPHY-BASED MASS SCREENING IN VICTORIA

Prepared by the Amalgamated Melbourne & Essendon Hospitals (AMEH)
and the Anti-Cancer Council of Victoria (ACCV)

Proposal

Mammography screening leads to a reduction of mortality from breast cancer in women.

Objective of Project

1. To determine the acceptability to a Victorian community of a mammography-based mass screening service.

2. To determine the costs of providing a mammography-based, mass screening service.

3. To establish standards for provision of a mammography-based mass screening service.

In order to complete the above, a pilot project is necessary to explore the best and most economical manner to deliver the service to a defined population. This is in order to determine whether it is feasible to introduce mass screening for breast cancer on a Victoria-wide basis. Thus, the project needs to discover how best to achieve:-

1. Compliance.

2. Good mammography.

3. Good film interpretation.

4. A practical reporting/notifying/counselling and recall system for patients having suspicious lesions.