

**The New South Wales State Cancer Council
Ministerial Advisory Committee
on Mammographic Screening**

**PROPOSED EXPANSION OF
MAMMOGRAPHIC SCREENING IN NSW
CALLS FOR EXPRESSIONS OF INTEREST**

MULTIDISCIPLINARY GROUPS INCORPORATING THE SKILLS REQUIRED TO ESTABLISH ASSESSMENT CENTRES WITH LINKED SCREENING UNITS ARE INVITED TO REGISTER THEIR INTEREST IN BEING CONSIDERED FOR ACCREDITATION AS PART OF THE PLANNED MAMMOGRAPHIC SCREENING PROGRAMME IN NSW.

The Minister for Health, the Hon. Peter Collins, MP, has approved a model for mammographic screening service delivery in NSW. It is envisaged that 5-10 multidisciplinary ASSESSMENT CENTRES will be capable of servicing 20-30 SCREENING UNITS in the public and private sectors. Each accredited Screening Unit will have the capacity to screen more than 5,000 women per year and will agree to refer women with abnormal mammograms to accredited Assessment Centres for work-up and treatment management plan.

Copies of the model are available from the address below.

In the first instance, interested groups will be asked to complete a detailed questionnaire. Subsequently, they will be invited to prepare a submission along the lines outlined in the model and these submissions will be considered by the Accreditation Sub-Committee.

The deadline for receipt of the completed questionnaire is WEDNESDAY 31ST JANUARY, 1990. It is anticipated that the accreditation process will be completed by the end of February 1990.

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**NSW
CANCER
COUNCIL** 

THE NEW SOUTH WALES STATE CANCER COUNCIL

B A C K G R O U N D D O C U M E N T

SCREENING FOR BREAST FOR CANCER BY MAMMOGRAPHY IN NSW

SCREENING FOR BREAST CANCER BY MAMMOGRAPHY IN NSW

1. BREAST CANCER CONTROL: WHY IT IS IMPORTANT

- 1.1 Breast cancer is the most common cause of cancer deaths among women in NSW (20%) and, indeed, the most common cause of death among women in the age group 30-60 years. The disease begins quite insidiously and can become advanced before producing any symptoms.
- 1.2 In 1982, the latest year for which we have accurate figures, there were 1,700 new cases of breast cancer in NSW and 711 deaths, about two deaths per day. Breast cancer incidence and mortality have not changed over the last few decades and the causes of breast cancer have not been defined.
- 1.3 In the past the accepted methods of early breast cancer detection have been clinical examination and breast self-examination (BSE).
- 1.4 Recent data from overseas studies indicate that under quality controlled circumstances periodic screening by mammography of symptomless women over the age of 45 has reduced breast cancer mortality by about one-third (equivalent to a reduction of five deaths per week in NSW) in women offered screening.

2. SCREENING: THE FACTS

- 2.1 Three major overseas studies have established the value of screening mammography: the randomised New York study (HIP) involving mammography and breast palpation reported an overall reduction in mortality of approximately 25% at ten

years in women aged 50 years and over; a randomised Swedish study of 135,000 women aged 40 to 74 reported a 31% reduction in deaths from breast cancer in the population offered periodic screening by mammography alone; and a non-randomised case controlled study of 43,000 Dutch women aged 35-65 which reported a 50% reduction in mortality in those who participated.

2.2 These studies are of relatively small populations and are based on committed radiological expertise and careful follow up.

2.3 A recent report of British studies on screening mammography and BSE indicated that the impact of mammography in a less rigorously controlled environment has not achieved a statistically significant reduction in mortality after the first 6-7 years of the trials.

2.4 If mammographic screening is to reduce breast cancer mortality, a high rate of compliance and provision of quality mammography must be combined with accurate pathological diagnosis and the provision of effective treatment. Essential ingredients of the success stories include the use of "dedicated" quality equipment, expert mammographic reading and appropriate management of screening-detected abnormalities.

2.5 Screening quality depends on several components including:

(a) the performance of radiographers in taking the x-rays and processing the mammographic films

(b) dedicated processing equipment

(c) the reporting skills of radiologists, and

(d) a dedicated data-base resource that allows both efficient conduct of the screening programme and implementation of quality control measures.

2.6 In order to achieve the sort of outcomes which have been reported from overseas, there is a need for adequately resourced pilot studies, to train the various experts involved in quality control, and also to explore the means of recruiting women to come for screening.

3. SCREENING FOR BREAST CANCER: THE CURRENT POSITION IN NSW

3.1 Current Projects

The two Government-funded pilot mammography screening projects in NSW (Central Sydney Area Health Service based at Rachel Forster Hospital, and the Hunter Area Health Service based at the Newcastle Mater Misericordiae Hospital) will play an important role in identifying strategies to achieve compliance. In addition, they will provide an opportunity for the development of standards, data-bases and training mechanisms for radiographers and radiologists.

Overseas models for the organisation of functioning screening activities based on a central facility and an outreach screening unit have been adopted in the two NSW Government-funded pilots.

A third study sponsored by the A.W. Tyree Foundation, through the Sydney Square Diagnostic Breast Clinic (SSDBC) based on "user pays" funding utilising facilities existing in private medical practice will be working in close co-operation with the government funded schemes.

3.2 Compliance (use of the Service by the target population of women)

It should be noted that experience of population screening in Australia is limited and experience in other countries is not necessarily directly transferable to Australia. The benefits which have accrued in the overseas studies will not be replicated in Australia unless women in the study population are persuaded to come forward for screening. The health consciousness in Australian women is less evident than in American and Northern European women. In addition, there is limited knowledge or experience of population screening amongst the medical profession in Australia.

3.3 Dedicated equipment

Modern x-ray equipment used only for mammography is required. New equipment has been purchased for the two pilot studies. In addition to the pilot project, it is estimated that dedicated mammography equipment which delivers a very low radiation dose to the women being screened, is now in use in more than 78 units in NSW as follows:

Public hospital - 6
Private hospital - 2
Private practice - 70

The need for dedicated film processing units has been identified overseas. The two pilot projects and the SSDBC have established this feature but it is believed that this is not the case for the majority of units in NSW.

3.4 Mammographic Expertise

Many radiologists in NSW have expertise in diagnostic but not screening mammography. Guidelines for the training of radiologists established by the European Group on breast cancer screening and the Swedish National Board of Health and Welfare suggest that a minimum of three months' training be undertaken by radiologists involved in a screening programme. Further, it is suggested that each screening centre should be performing around 10,000 mammograms per year and have access to a large and well-organised teaching file.

The two Government-funded pilots and the proposed (private) screening programme based on the Sydney Square Diagnostic Breast Clinic may be of assistance in the training and accreditation of radiologists. Even with committed radiological expertise it would remain to be seen whether the standards achieved elsewhere can be reproduced here, as there is no guarantee that radiologists will accept the need for extensive special training, as referred to above.

Radiographers require training and experience at a screening facility. It should be noted that there is a critical shortage of both qualified radiographers and training positions in Australia so there is, and will remain, a limited pool of qualified staff to operate this equipment.

3.5 Central Data Collection

There is a need to ensure that all screening activities are linked to State and Federal data facilities and there is therefore a requirement to use compatible computer software and data-bases. Information needs to be collected to allow

calculation in the following:

- compliance rate
- recall rate
- proportion of "benign" to abnormal reports
- the positive predictive value of "abnormal" reports
- the outcome of recall
- the number of biopsies performed
- the number of benign lesions, in situ and invasive cancers
- the number with local or systemic spread
- the use of cytology or pathology in diagnosis
- treatment given
- the number of true interval cancers
- the number of false negative mammograms

3.6 Follow-up of mammographic abnormalities

Screening programmes must have a reliable and appropriate mechanism for the recall and evaluation of women with suspicious mammograms. Follow-up requires full mammography facilities, real-time sonography and access to clinical and cytopathological expertise for the management of screening-detected lesions. It should be noted that in NSW expert co-ordinated services in breast cancer diagnosis by radiology, pathology and specialised surgery will need to be developed within the organisation of local hospitals.

3.7 Cost factors

In the absence of information relating to local performance estimates of cost generation must be based on screening programmes overseas, in different health-care systems with economies of scale and centralisation of follow-up and management.

The requirement for dedicated, "state-of-the-art" equipment and screening expertise means that initial establishment costs are high. However, experience from the Swedish study shows that screening programmes will more than pay for themselves after five years, by offsetting the costs of treating fewer advanced breast cancers.

The majority of quality screening units overseas not only have dedicated equipment but also have an annual throughput of more than 10,000 women. Under these circumstances the costs per cancer detected by mammographic screening programmes are large but need to be contrasted with the costs per life year gained of other health care interventions. In the UK calculations, a cost of £3,309 per quality-adjusted life year (QALY) for mammographic screening is similar to kidney transplantation (£3,000/QALY) and less than the £5,000/QALY for heart transplantation programmes and £12,000 for coronary artery bypass grafts for moderate angina with one vessel disease (BMJ, 291, 326-329, 1985).

3.8 Issues Still to be Resolved

In addition to obstacles identified above which need to be overcome, experts have still not reached agreement on the following issues:

(a) Frequency of screening

The British have allocated funds to establish three-yearly screening of all women aged 50-64 years. However, this is a compromise position based on economic considerations and perhaps the interval should be shorter. Dr Laszlo Tabar, the Swedish expert, recommends 12-18 months intervals in the 40-49 age group and 18-24 months thereafter.

Initially, the planned screening interval in the Central Sydney Area Health Service pilot is three years and in the Hunter Area Health Service it is one year for women up to the age of 54 and two years over the age of 54. These intervals will be reviewed as the pilot studies progress. The SSDBC study proposes to rescreen at 18 month intervals in women over 40 years.

(b) Age at which to commence screening

There is as yet no consensus about the age at which screening should commence. In overseas studies, initial analysis of the data indicated that the benefit of screening segregates to older women and is significant only in women aged 50 years or more. More recent analysis of American data shows that screening has the same benefit in the 40-50 year age group as in those women over 50. (Based on further analysis of the HIP studies and information from the Breast Cancer Detection and Demonstration Project (BCDDP) of the American Cancer Society and National Cancer Institute of America.)

(c) The Number of Mammographic Views

Single oblique view mammography has been advocated by some as it allows a greater throughput of screenees in a given time period and thereby reduces cost. However, two-view mammograms should increase the detection rate and reduce the recall rate, leading to cost savings and reduction in unnecessary anxiety. Local data addressing this issue are required.

(d) Whether there is a Need for Double Reading of Each Film

During the period of training, there is a clear need for double or triple reading of each film. When there are sufficient trained staff with experience of mammographic screening then the need for double reading should be reassessed. Similarly when there are adequately trained radiologists to conduct screening the role of non-radiologists in film reading should be investigated.

(e) Consensus on Management of Abnormalities Detected by Screening Mammography

Such bodies as the Royal Australasian College of Radiologists, Royal College of Pathologists of Australasia and the Royal Australasian College of Surgeons need to collaborate on the development of management protocols for mammography detected abnormalities.

4. STAGED EXPANSION OF SCREENING

The present equipment in NSW is sufficient to support expansion of the screening services. What is lacking, however, is a commitment to undertake screening according to agreed guidelines with a defined population base. Moreover, the commitment by radiologists to specialise in screening mammography, eg. to screen 10,000 women per year, has not been demonstrated. However a recent survey of private radiology practices with mammography units in NSW reveals a willingness to participate in quality control measures and in centralised data collection. Whether or not the existing equipment can be utilised in the provision of standardised high quality screening remains to be seen.

However, the Royal Australasian College of Radiologists is the appropriate body to be consulted in the development of accreditation criteria (see below).

The staged expansion of screening will require:

- * appropriately qualified and trained radiographers, and radiologists
- * the agreement to refer women with abnormal mammograms to identified and appropriately equipped diagnostic services
- * the use of a common computerised data base for data collection and reports.

4.1 Before any expansion can be considered the two pilot projects and the SSDBC study need to demonstrate that they can achieve agreed standards. With the co-operation of the College of Radiologists the following standards need to be defined and the mechanisms for review established:-

- (a) acceptable radiographic quality
- (b) acceptable levels of recall
- (c) acceptable benign/malignant biopsy ratios
- (d) realistic cancer detection rates

In addition the pilot studies need to demonstrate an acceptable rate of screening within their target populations and must provide realistic estimates of the establishment and recurrent costs for this rate of screening.

- 4.2 Once the above has been achieved for quality mammographic screening to be made accessible to greater numbers, it is proposed that the following model be adopted.

Within a defined area mammographic screening units will refer women with abnormal mammograms to an assessment centre where the required diagnostic facilities and surgical expertise exist. Such centres may service several (3-5) screening units each with a throughput of about 10,000 women per year.

In many cases the peripheral units will be mobile and some may be located in a private practice which has demonstrated achievement of the agreed standards.

Since this model requires that new screening units should be linked to appropriately staffed and equipped assessment centres, the planned expansion of screening can proceed either:

- (i) with new units linked to the existing assessment centres at The Rachel Forster or Newcastle Mater Misericordiae Hospitals, or
- (ii) by the establishment of new assessment centres where the appropriate facilities and expertise can be demonstrated.

The Royal Australasian College of Radiologists and the Royal Australian College of Surgeons should assist in the identification of such centres.

If population screening is ultimately to be implemented the total number of assessment centres and screening units required will be greatly influenced by the size of the target population, the geographical spread of that

population and the frequency of screening.

- 4.3 The expansion of mammographic screening can only proceed when the means of funding that expansion have been agreed and the required staff recruited and trained.

Funding options can be via project grants provided by the State Government or on a "user-pays" basis. The provision of a Medicare rebate before the structure for quality control and performance assessment has been established must be resisted. When introduced such a rebate should be tied to approved facilities that meet the agreed standards.

With the resolution of the funding question and adoption of the model there still remains the requirement to recruit and train sufficient numbers of radiographers and radiologists to allow staged expansion to proceed.

Additional funds are required for the existing assessment centres to take on this training role.

An appropriate body should be charged with responsibility for overseeing the orderly development and expansion of mammographic screening in NSW. This role could well be delegated to the Breast Cancer Working Party of the NSW Cancer Council.

THE NEW SOUTH WALES STATE CANCER COUNCIL

M O D E L

FOR THE

EXPANSION OF MAMMOGRAPHIC SCREENING

IN NEW SOUTH WALES

This document was accepted by the Minister for Health,
Mr Peter Collins in June 1989.

EXPANSION OF MAMMOGRAPHIC SCREENING IN NSW

SUMMARY

The model for mammographic screening service delivery in NSW consists of a number of multidisciplinary ASSESSMENT CENTRES to which women with abnormal screening mammograms will be referred for further investigation. Each ASSESSMENT CENTRE will be capable of servicing several SCREENING UNITS in the public or private sectors. Each SCREENING UNIT will have a substantial through-put of screenees (5,000 screenees per year) and will agree to refer women with abnormal mammograms to designated ASSESSMENT CENTRES. (See Appendix 1.)

RECOMMENDATIONS

There are three elements to the expansion of mammographic screening in NSW:-

A. Expansion of Existing Research and Development Pilot Projects

- (i) Additional resources are required to allow the existing mammographic pilot screening projects to fulfil their initial population coverage in a reasonable time. Rescreening should commence after the majority of the initial target population has been screened once.
- (ii) Resources are required to allow these original screening projects to expand their target population, and to acquire new SCREENING UNITS to feed into the existing ASSESSMENT CENTRES.

B. Research into the optimal organisation of designated ASSESSMENT CENTRES.

The main function of the pilot projects has been in the development of screening strategies and the development of screening expertise using existing hospital services. Research is needed to identify the most effective means of developing new assessment centres.

Amongst the issues to be addressed are:

- (i) The relationship of screening ASSESSMENT CENTRES to establish symptomatic breast clinics.
- (ii) The appropriate mix of disciplines and skills in an ASSESSMENT CENTRE (recall, workup and counselling).
- (iii) How to ensure that patients diagnosed with breast cancer receive appropriate treatment and follow up.

C. Creation of new ASSESSMENT CENTRES, to be identified, around which SCREENING UNITS can be developed.

1. Two means of identifying additional ASSESSMENT CENTRES should be considered:-

- (i) a call for applications;
- (ii) a direct approach to specific individuals or groups known to have already developed some of the expertise necessary to run an ASSESSMENT CENTRE.

It is recognised that specific regions within NSW may self-select based on community interest and availability of appropriate expertise.

2. Crucial elements of an ASSESSMENT CENTRE (see Appendix 2) include personnel with expertise in the following:-

- (i) specialised radiology of the breast;
- (ii) ultrasonography of breast disease;
- (iii) breast histo- and cyto-pathology;
- (iv) surgical management of breast disease;
- (v) counselling of patients with breast disease;
- (vi) administration of interdisciplinary units;
- (vii) data management.

3. The physical requirements are:-

- (i) state of the art mammographic equipment;
- (ii) state of the art sonography;
- (iii) facilities for magnification mammography;
- (iv) facilities for specimen mammography;
- (v) facilities for stereotactic localisation of impalpable mammographic abnormalities;
- (vi) appropriate computerised data management systems to maintain a minimum and standardised data set.

In addition, all ASSESSMENT CENTRES should agree to:-

- (i) provide facilities for the appropriate investigation of women with screening-detected mammographic abnormalities;
- (ii) undertake a random review of screening films from the SCREENING UNITS which they service;
- (iii) provide the results of their investigations of women with abnormalities referred to them from SCREENING UNITS not only to the women and their GPs but also to the SCREENING UNIT and the State Breast Screening Registry;
- (iv) provide training for radiographers, radiologists and clinicians specialising in breast diseases;

Finally, all ASSESSMENT CENTRES must be fully accredited by the Royal Australasian College of Radiologists (RACR) (Appendix 3), the Royal College of Pathologists of Australia, the Australian Society for Ultrasound in Medicine and the Royal Australasian College of Surgeons (RACS).

4. Resources Required

In order to encourage the establishment of these new ASSESSMENT CENTRES it is recommended that resources be provided for organisations which agree to establish these centres and work within the guidelines. These resources should:

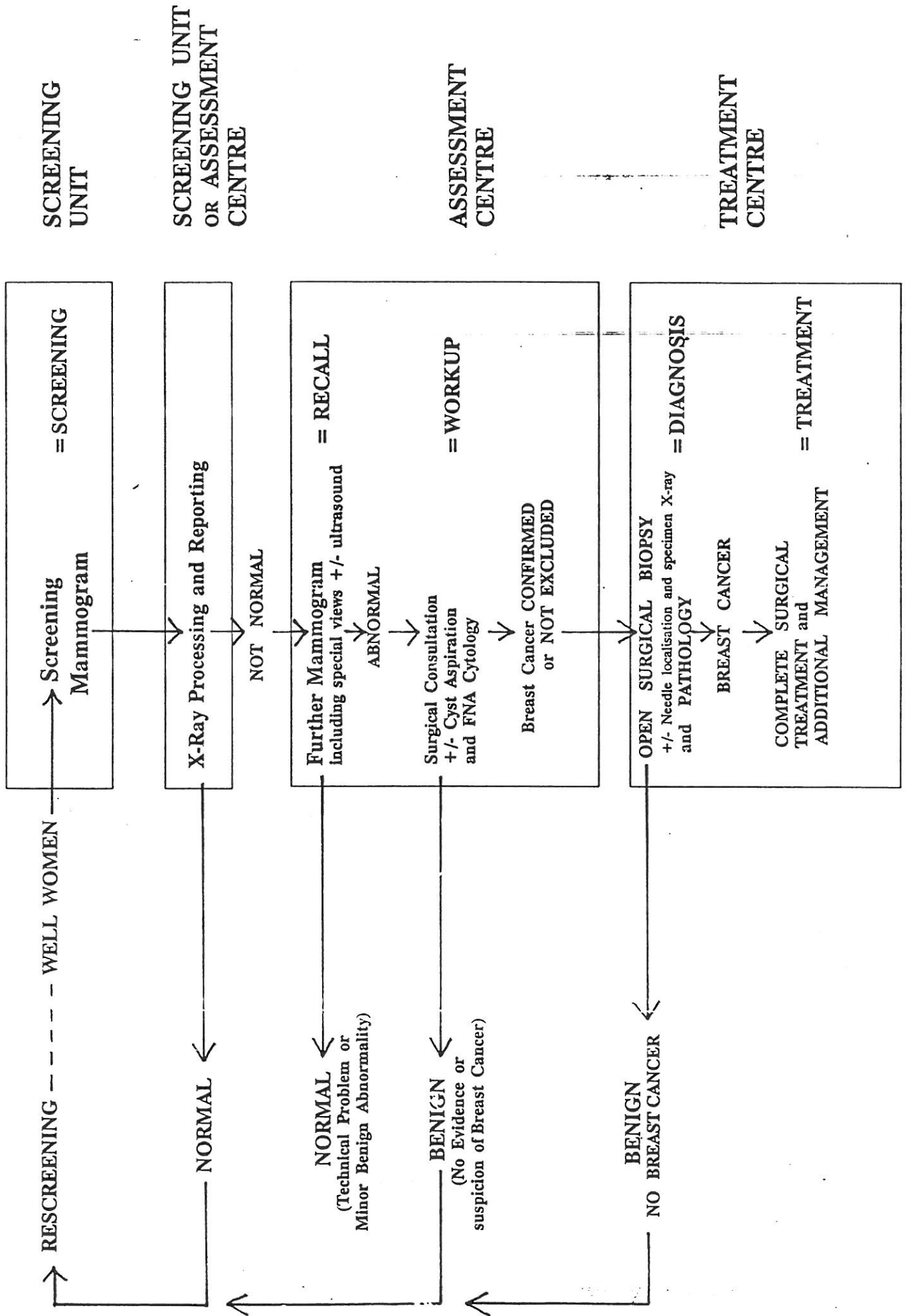
- (i) go towards covering payments for radiologists working in the centre

- (a) reviewing screening mammograms and
 - (b) performing the crucial functions of the
ASSESSMENT CENTRE (see Appendix 2)
- (ii) meet the costs of specialised equipment;
 - (iii) cover the cost of administrative functions and
data management;
 - (iv) cover the cost of adequate extra staffing to
allow proper training of all levels of staff.

The number of ASSESSMENT CENTRES which are required and the rate of expansion of the programmes will be influenced greatly by the availability of trained staff, the number of SCREENING UNITS, the rescreening interval, and the age of those to be screened.

It is notable that in the UK the age of the screening population is limited to 50-64 years and the screening interval recommended for their National Screening Programme is three years. This interval is generally considered to be suboptimal and an economic compromise. In Australia, the first goal must be to recruit women for their first screen and we recommend no upper age limit. Review of the lower age limit and screening frequency will be required.

BREAST CANCER SCREENING MODEL



APPENDIX 2

COMPONENTS OF THE MODEL
FOR MAMMOGRAPHIC SCREENING IN NSW

SCREENING UNIT

A SCREENING UNIT cannot be developed independently of an ASSESSMENT CENTRE. There will be a variety of ways by which SCREENING UNITS will be funded. However, the performance of all SCREENING UNITS must be monitored and quality control methods must be seen to be in operation.

A SCREENING UNIT must agree:

- (i) to register all women having screening mammograms on the State Breast Screening Registry;
- (ii) to provide a random selection of their screening films for quality control;
- (iii) to follow guidelines in relation to frequency of rescreening;
- (iv) to document interval cancers.

ASSESSMENT CENTRE (Recall/Workup)

Approximately 10% of women attending a mammography SCREENING UNIT will be recalled to an ASSESSMENT CENTRE for evaluation of possible screen detected abnormalities.

The aim of an ASSESSMENT CENTRE is to determine whether the possible abnormality detected by screening is of any significance and whether surgical biopsy is needed. Most women recalled to an ASSESSMENT CENTRE will not require surgery. Surgery will be

required for approximately 2% of the total screening population.

The activities of an ASSESSMENT CENTRE are:-

- (a) Further imaging including repeat mammography views, specialised mammographic techniques and ultrasound examination of the breast.
- (b) Clinical examination of the breast.
- (c) Fine needle aspiration biopsy.
- (d) Surgical specialist consultation.

Assessment findings and any plans for further management need to be discussed personally with the women.

Resources Required

- Quality mammography equipment including facilities for accurate localisation and FNA cytology sampling of impalpable x-ray abnormalities (specifications to be defined by the RACR).
- Dedicated processing equipment (to be defined by the RACR).
- Ultrasound equipment (standard to be defined by the RACR and the Australian Society for Ultrasound in Medicine).
- Trained radiographers dedicated to mammography including a minimum of one senior and one junior radiographer per ASSESSMENT CENTRE.
- A minimum of two radiologists trained in mammography, breast ultrasound and localisation techniques.

- An efficient computerised data base to monitor patients, appointments, recalls, results, outcome, follow up and statistical analyses.
- A cytotechnician, a cytopathologist and a pathologist skilled in interpreting breast cytology and histology specimens, preferably on site.
- Specialist breast surgeons, trained in the management of all aspects of breast pathology including breast cancer.

These specialists should be available for consultation at the time a woman completes her recall workup, so that the need for open surgical biopsy and further management can be discussed and planned without unreasonable delay.

- Sufficient staff to maintain efficient reception, filing and other clerical and data base activities.
- Staff trained to undertake patient education and counselling.

TREATMENT CENTRE (Surgical Diagnosis/Treatment)

Women will be referred from the ASSESSMENT CENTRE to the TREATMENT CENTRE either because they have a cytologically confirmed breast cancer or a breast lesion which requires open surgical biopsy.

Following confirmation of the diagnosis of breast cancer, relevant staging investigations will be undertaken before recommendations and treatment options are discussed. These may require consultation with non-surgical breast cancer experts, for example, radiation oncologists and medical oncologists.

Resources Required

- An experienced specialist breast surgeon trained in the use of localisation methods for surgical biopsy and the management of all types of breast pathology including breast cancer.
- Ready access on site to mammography facilities for accurate localisation of non-palpable lesions for surgical biopsy.
- Ready and direct access to skilled pathology.
- Provision for specimen x-ray following localisation biopsy to ensure that mammographically detected lesions such as calcification are properly removed.
- Ready access to specimen assay facilities for biological markers.
- Direct access for face-to-face consultation with other specialist staff who may be involved in the management of breast cancer. This should include consultation with medical oncologists, radiation oncologists, and other medical or surgical specialists as appropriate. Patients may need, for example, plastic surgery consultation when breast reconstruction is part of their management.
- Provision of all mammography x-rays in the operating theatre.
- Provision for surgical biopsy specimens to be rapidly and safely transported between the operating theatre, specimen x-ray site and pathology.
- Adequate operating facilities including day care, inpatient, local and general anaesthetic support.
- Staff trained to undertake patient education and counselling.



The Royal Australasian College of Radiologists

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ACCREDITATION GUIDELINES FOR SCREENING MAMMOGRAPHY FACILITIES

APPROVED BY RACR COUNCIL 10 MARCH 1989

ACCREDITATION GUIDELINES

1. Mammographic method

Film/screen technique

2. Equipment

The Accredited facility will have dedicated mammography equipment which meets acceptable specifications for screening mammography. The specifications of NHTAP are helpful as a guide. The specifications of equipment in each facility will be assessed during accreditation.

3. Processing

Special processing is of value in dose reduction and film contrast improvement. At present, development time should not be less than 40 seconds at a temperature not below 35°C.

Processing performance must be assessed daily using a sensitometric strip and densitometry, and charted. These results to be available for quality control checks. An efficient form of chemical mixer is desirable.

4. Quality control

4.1 A central quality assurance program will be instituted by the College. Use of this program will be a requirement for accreditation.

5. Radiologist

5.1 The Radiologists performing screening mammography in an accredited facility will have received an acceptable level of formal training and experience in mammography.

5.2 One such radiologist must be nominated to be in charge of each accredited facility.

5.3 Continuing Accreditation of the unit will depend on evidence of continuing experience and continuing education of the radiologists, and analysis of their performance in screening.

5.4 Those being trained in the unit will be adequately supervised by the nominated radiologist in charge.

6. Radiographers

6.1 The accredited mammography facility should employ only radiographers with experience in mammography. If it is necessary to train radiographers in the facility then they must work under the supervision of an experienced mammography radiographer.

7. Protocol for client management

7.1 It is the responsibility of the nominated radiologist in the accredited facility to inform both the client and the appropriate medical colleague of the result of the screening. With positive results it is the Radiologist's responsibility to make all reasonable effort to ensure that the appropriate people are informed.

7.2 The unREFERRED client raises particular problems in this regard. Such clients should be asked to nominate a medical practitioner and this practitioner as well as the client should be informed of the screening result. If no medical practitioner is nominated there is particular responsibility on the radiologist in regard to adequate follow-up of positive screening results. The radiologist has a responsibility to aid the client in seeking appropriate medical care.

8. Data Collection

It is the responsibility of the nominated Radiologist in an accredited facility to collect and maintain records concerning all screened clients. The minimal requirement will be to maintain a register of clients with the results of screening and follow-up data.

The facility must co-operate with any central coordinating data collection agency approved by the College for the purpose of monitoring mammography screening.

The College must have access to the records of each facility for the purposes of continuing accreditation assessment.

9. Reporting

Reporting will only be by Radiologists nominated and approved through the RACR accreditation of mammography facilities system. Reporting of initial screening in a facility should not be of a narrative type but of such a nature to clearly indicate that the examination was clear, or that the client should return for further assessment.

9. Reporting Cont

Reports of recall mammography should similarly state clearly that the examination is negative for cancer and that the client should return to regular screening or that the mammogram is positive and that the patient requires clinical assessment. A narrative description of abnormalities detected should be provided as well.

10. Storage of films

The nominated Radiologist has the responsibility to ensure to the best of his ability that the mammography films are stored in such a manner that they can be reclaimed for comparison study at later screening examinations. Film storage and copying facilities must be available on site.

11. Advertising

Publicity statements and advertising of accredited mammographic screening facilities should meet medical ethical standards.

12. Informed consent

Informed consent may be necessary as regards the use of the patient's data for record keeping, particularly if a central data collection agency is involved. Relevant information about mammographic screening should be made available, including information regarding false positive and negative results. Consent in regard to obtaining surgical and pathology reports and copying films may be necessary.

THE NEW SOUTH WALES STATE CANCER COUNCIL

MINISTERIAL ADVISORY COMMITTEE ON MAMMOGRAPHIC SCREENING

PRELIMINARY SURVEY TO IDENTIFY POTENTIAL FOR ACCREDITATION AS AN ASSESSMENT CENTRE

Before completing the questionnaire it is important to consider your answers in relation to the approved model. Please note that the first stage involves selection of Assessment Centres. It is only once the Assessment Centres have been identified that associated Screening Units can be considered.

Please complete ALL questions.

1. Does your group possess or plan to purchase the following items of equipment meeting the standards specified by the Royal Australasian College of Radiologists?

	Yes	Plan to purchase	Neither
Dedicated mammography equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify make and model			

Dedicated film processing equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facilities for fine needle aspiration cytology sampling of impalpable lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify make and model			

Ultrasound equipment suitable for breast work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify make and model			

Facilities for accurate localisation of impalpable mammographic lesions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Does the group have radiologists trained in mammography? Yes No
How many (full time equivalents)? Number

Name(s)	Years of experience in mammography	Trained in screening mammography	
		Yes	No
_____		<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>
_____		<input type="checkbox"/>	<input type="checkbox"/>

3. Does the centre have radiologists trained in breast localisation techniques? Yes No
How many (full time equivalents)? Number

4. Does the group have trained radiographers dedicated to mammography? Yes No
How many senior radiographers (full time equivalents)? Number

Name(s)	Years of experience in mammography

How many junior radiographers (full time equivalents)? Number

5. Does the centre have specialists trained in breast ultrasound? Yes No
How many (full time equivalents)? Number

Name(s)	Years of experience in breast ultrasound

6. Is a cytopathologist skilled in interpreting breast cytology specimens available? Yes No
- If yes, does he/she interpret on site?
- Name(s) Years of experience in breast cytology

7. Is a cytotechnician available to attend fine needle aspiration biopsies performed by surgeons or radiologists?

8. Does the group include at least one pathologist skilled in interpreting breast histology specimens? Yes No

If yes, does he/she interpret on site?

Name(s) Years of experience in breast histology

9. Does the group include specialist breast surgeons, experienced in the management of all aspects of breast diseases including breast cancer? Yes No

If yes, how many?

Name(s) Years of experience in breast surgery Approx. number of breast procedures p.a.

10. Please attach curricula vitae of the medical practitioners named above.

11. Will a computerised record system be available for monitoring:-
- | | Yes | No |
|--------------|--------------------------|--------------------------|
| screenees | <input type="checkbox"/> | <input type="checkbox"/> |
| appointments | <input type="checkbox"/> | <input type="checkbox"/> |
| recalls | <input type="checkbox"/> | <input type="checkbox"/> |
| results | <input type="checkbox"/> | <input type="checkbox"/> |
| outcome | <input type="checkbox"/> | <input type="checkbox"/> |
| follow up | <input type="checkbox"/> | <input type="checkbox"/> |

12. Will a computerised record system be available for statistical analysis?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

13. Does the group have staff for data base management?
- | | Yes | No |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |

14. Is the group prepared to provide patient education and counselling services?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

15. Does the group have an established quality assurance programme?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

If yes, please summarise the components of the programme.

16. Is the group prepared to contribute data about screenees to a central body for the purposes of quality assurance?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

17. Is there a frequent (at least weekly) clinical meeting where radiologists, pathologists and surgeons can meet to discuss the patients seen in the Assessment Centre?
- | | | |
|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

18. Where do you propose to locate your ASSESSMENT CENTRE?
(Please indicate whether existing or planned. If existing, outline any proposed changes)
-
-
-
-

19. Have you identified possible SCREENING UNITS
and their potential population for screening? | | | |

If yes, please specify where the units would be located and the target
population

20. Do you have any further comments?

Please return to: The Secretary
 The Ministerial Advisory Committee on
 Mammographic Screening
 New South Wales Cancer Council
 GPO Box 7070
 SYDNEY NSW 2001

NAME: _____

ADDRESS: _____

PLANNING FOR A MAMMOGRAPHIC SCREENING PROGRAMME IN NSW

LADIES & GENTLEMEN

YOUR ATTENDANCE HERE THIS EVENING WAS NO DOUBT TO SOME EXTENT PROMPTED BY THIS NOTICE WHICH HAS APPEARED RECENTLY IN THE SYDNEY MORNING HERALD, THE MJA AND THROUGH YOUR LETTERBOX.

SLIDE OF FLYER HERE

I WANT TO SPEND A FEW MOMENTS GOING OVER THE BACKGROUND AND THE PATHWAY THE CANCER COUNCIL HAS TAKEN TO REACH THIS POINT, THE SIGNIFICANCE OF THE CALL FOR EXPRESSIONS OF INTEREST IN ESTABLISHING ^{MULTIDISCIPLINARY} ASSESSMENT CENTRES, AND PERHAPS CLARIFY WHAT MIGHT BE SOME MISCONCEPTIONS OF THE POSITION OF THE CANCER COUNCIL ON MAMMOGRAPHIC SCREENING.

HISTORICAL PERSPECTIVE

INTEREST IN ESTABLISHING BREAST CANCER SCREENING PROGRAMS IN AUSTRALIA INTENSIFIED ONCE THE RESULTS OF THE SWEDISH AND N.Y. (HIP) STUDIES WERE PUBLISHED.

IN 1985, THE AUSTRALIAN CANCER SOCIETY CONVENED A MEETING OF BREAST CANCER EXPERTS. THIS MEETING CONCLUDED THAT THE EVIDENCE OF MORTALITY REDUCTION BY POPULATION-BASED MAMMOGRAPHIC SCREENING WAS CONVINCING. HOWEVER, IT WARNED THAT THE RESULTS OF OVERSEAS STUDIES CANNOT NECESSARILY BE ~~EXPECTED~~ ^{IN} TRANSLATED TO AUSTRALIA.

SEVERAL QUESTIONS AROSE:

- WILL AUSTRALIAN WOMEN WISH TO PARTICIPATE IN BREAST SCREENING PROGRAMS?
- DO WE HAVE THE NECESSARY TECHNOLOGY AND RESOURCES?
- HOW BEST CAN SCREENING BE INTRODUCED IN A SOCIETY WITH A MIX OF PUBLIC AND PRIVATE MEDICINE?
- ALTHOUGH REDUCTION OF MORTALITY HAS BEEN DEMONSTRATED IN THE 50-70 YEAR OLD AGE GROUP SHOULD YOUNGER WOMEN ALSO BE SCREENED?
- SHOULD ONE OR TWO VIEWS OF THE BREAST BE TAKEN?
- SHOULD SCREENING BE SOLELY BY MAMMOGRAPHY OR SHOULD WOMEN ALSO BE EXAMINED CLINICALLY?

- IF PHYSICAL EXAMINATION IS REQUIRED MUST THIS BE
DONE BY A DOCTOR OR COULD NON-MEDICAL PERSONNEL
CONDUCT THE EXAMINATION?

TO EXAMINE THESE AND OTHER QUESTIONS, IT WAS SUGGESTED THAT A
NUMBER OF PILOT PROJECTS BE ESTABLISHED IN AUSTRALIA, EACH
ADDRESSING DIFFERENT FACETS OF THE PROBLEM AND EACH
CONTRIBUTING TO A POOLED EXPERIENCE FROM WHICH A NATIONAL
POLICY COULD BE DEVELOPED. THE FEDERAL GOVERNMENT ANNOUNCED
IN 1987 THAT IT WOULD MAKE FUNDS AVAILABLE TO EVALUATE
SCREENING FOR BREAST CANCER, AND, THROUGH THE AUSTRALIAN
HEALTH MINISTERS' ADVISORY COUNCIL, ESTABLISHED A WORKING
PARTY TO CONSIDER THE PROBLEM.

IN NSW, THE CANCER COUNCIL'S BREAST CANCER WORKING PARTY, IN
1986, HAD PERSUADED THE THEN MINISTER FOR HEALTH, PETER
ANDERSON, THAT A PILOT OR DEMONSTRATION PROJECT OF SCREENING
MAMMOGRAPHY CARRIED OUT IN A RIGOROUSLY CONTROLLED ENVIRONMENT
WITH DEDICATED QUALITY EQUIPMENT, COMMITTED RADIOLOGICAL
EXPERTISE, AND PROPER MANAGEMENT OF SCREEN DETECTED
ABNORMALITIES/^{TOGETHER} WITH CENTRALISED DATA COLLECTION SHOULD BE
FUNDED TO SEE WHETHER WE COULD ACHIEVE THE FOLLOWING IN THE
CENTRAL SYDNEY AREA HEALTH SERVICE.

SLIDE * HIGH COMPLIANCE RATE
* PROVISION OF QUALITY MAMMOGRAPHY
* ACCURATE PATHOLOGICAL DIAGNOSIS
* PROVISION OF EFFECTIVE TREATMENT

MARY RICKARD WILL BE GIVING SOME OF THE RESULTS LATER THIS EVENING.

A SECOND PILOT WAS FUNDED IN 1988 IN THE HUNTER HEALTH AREA BASED AT THE NEWCASTLE MATER WHICH WOULD PROVIDE EXPERIENCE IN A RURAL SETTING TO COMPARE WITH THE CENTRAL SYDNEY URBAN PILOT; AND LATER IN 1988 A THIRD PILOT IN THE PRIVATE SECTOR FUNDED BY THE TYREE FOUNDATION COMMENCED THROUGH MEDICHECK CHARGING A REDUCED FEE OF \$42 PER SCREEN.

AROUND THAT TIME, ADVANTAGE WAS TAKEN OF THE EXPERTISE AVAILABLE IN THE FORM OF OVERSEAS SPEAKERS PARTICIPATING IN THE BICENTENNIAL BREAST CANCER CONFERENCE HELD AT LEURA. WITH THE HELP OF THE CANCER COUNCIL'S GUEST, SIR PATRICK FORREST, WE WERE ABLE TO CONVINCED THE MINISTER, WHO WAS BY THIS STAGE PETER COLLINS, THAT A CENTRAL AUTHORITY WAS REQUIRED TO PLAN FOR THE POSSIBILITY OF INTRODUCING A STATEWIDE PROGRAMME.

THE MINISTER WAS WELL AWARE THAT THE CANCER COUNCIL'S VIEW WAS AS COMMUNICATED IN THE LETTERS TO THE EDITOR PAGE OF THE SYDNEY MORNING OF 17 FEBRUARY 1989 VOICING OUR CONCERN IN RESPONSE TO AN ARTICLE BY MARGARET RICE ON THE FRONT PAGE OF A PREVIOUS EDITION CALLING FOR IMMEDIATE INTRODUCTION OF MAMMOGRAPHIC SCREENING - I QUOTE:

"MARGARET RICE HAS ASSUMED THAT THE LOGISTICS OF A SCREENING PROGRAMME AND TECHNIQUES TO ENSURE POPULATION COMPLIANCE ALREADY EXIST. A FURTHER ASSUMPTION IS THAT EXPERTISE IS UNIFORMLY DEVELOPED AND READILY AVAILABLE THROUGHOUT AUSTRALIA TO ASSESS ANY ABNORMALITIES WHICH ARE DETECTED AND TO MANAGE THESE RAPIDLY AND WITH THE MINIMUM DISTURBANCE TO THE WOMAN. THIS IS NOT SO. IT IS THEREFORE ESSENTIAL THAT THE WOMEN OF AUSTRALIA REALISE THAN AN ENORMOUS GAP EXISTS BETWEEN THE ACADEMIC STUDIES WHICH HAVE SHOWN THE POTENTIAL OF MAMMOGRAPHIC SCREENING AND THEIR CONFIRMATION ON A NATIONAL BASIS IN AUSTRALIA OR IN ANY OTHER COUNTRY FOR THAT MATTER.....

"THE MAIN THRUST OF THE ARGUMENT MUST NOW BE THAT THE IMPORTANT SECOND PHASE OF PLANNING FOR A CAREFULLY CONTROLLED EXPANSION FROM THE CURRENT PILOTS SHOULD BE TAKING PLACE AND SHOULD NOT BE DEFERRED UNTIL AFTER THEIR EVALUATION BY THE FEDERAL GOVERNMENT. IN NSW, A STRATEGIC PLAN IS BEING DEVELOPED FOR SUCH CONTROLLED EXPANSION."

IN APRIL 1989, THE MINISTER APPOINTED THE COUNCIL'S BREAST CANCER WORKING PARTY AS HIS ADVISORY COMMITTEE ON MAMMOGRAPHIC SCREENING, AUGMENTED BY REPRESENTATIVES FROM THE COLLEGE OF RADIOLOGISTS, SURGEONS AND PATHOLOGISTS AND INCLUDING A HEALTH ECONOMIST AND EPIDEMIOLOGIST.

SLIDE OF MEMBERSHIP OF CMT

THAT COMMITTEE HAS BEEN MEETING WITH THE MINISTER DURING THE PAST YEAR PRESENTING A RATIONALE AND MODEL FOR ANY SUCH PROGRAMME IN NSW. THE MINISTER HAS ACCEPTED THE RECOMMENDATIONS OF HIS COMMITTEE AND HAS SET A TIMETABLE HE WOULD LIKE OBSERVED DURING 1990.

THE MAJORITY OF YOU NOW HAVE COPIES OF THE DOCUMENTS.

IT SHOULD BE UNDERSTOOD THAT, ALTHOUGH A GREAT DEAL OF EFFORT, EXPERTISE AND PLANNING HAS GONE INTO PROVIDING THIS MODEL, IT SHOULD NOT BE TAKEN AS A FAIT ACCOMPLI THAT A STATEWIDE MAMMOGRAPHIC PROGRAMME WILL GO AHEAD. MUCH DEPENDS ON WHAT HAPPENS AT THE COMMONWEALTH LEVEL AND THE FEDERAL MINISTER IS AWAITING A REPORT FROM THE SCREENING EVALUATION CO-ORDINATION UNIT (SECU) AT THE AUSTRALIAN INSTITUTE OF HEALTH WHICH HAS BEEN EVALUATING VARIOUS ASPECTS OF THE PILOT PROJECTS DURING THE PAST FEW YEARS AND THIS REPORT IS NOT EXPECTED UNTIL JUNE OF THIS YEAR. NSW NEEDS FEDERAL FUNDING.

IT IS OF THE UTMOST IMPORTANCE, HOWEVER, THAT THE DEBACLE ASSOCIATED WITH THE OTHER CANCER SCREENING PROGRAMME IN NSW - THAT OF CERVICAL CANCER - SHOULD BE AVOIDED AND IT HAS BEEN THE INTENTION OF THE CANCER COUNCIL TO HAVE A STRATEGIC PLAN IN PLACE IN THE EVENT THAT THE GREEN LIGHT IS GIVEN, FOR MAMMOGRAPHIC SCREENING.

WOMEN, AT LEAST IN THE HIGHER SOCIOECONOMIC GROUPS, WANT IT BUT NO SCREENING IS BETTER THAN BADLY DONE SCREENING.

IT IS SUGGESTED THAT UNCONTROLLED DEVELOPMENT OF SERVICES WILL HAVE THE POTENTIAL TO DO HARM THROUGH:

- * HIGH RECALL RATES OF SCREENED WOMEN FOR FURTHER INVESTIGATION
- * UNNECESSARY BIOPSIES IN ASYMPTOMATIC WOMEN
- * UNNECESSARY MASTECTOMIES
- * DIVERSION OF FUNDS FROM OTHER NEEDED HEALTH SERVICES

AND WILL FAIL TO REACH THE OVERALL OBJECTIVE OF A REDUCTION IN MORTALITY FROM BREAST CANCER.

GOLD STANDARD FOR MAMMOGRAPHIC SCREENING

LAZLO TABAR HAS SET THE STANDARD FOR MAMMOGRAPHIC SCREENING AS DEPICTED IN THE FLOW CHART:

SLIDE: FLOW CHART

OF 1000 WOMEN WHO PRESENT FOR THE FIRST ROUND OF SCREENING (PREVALENT SCREEN) BY SINGLE-VIEW OR TWO-VIEW MAMMOGRAPHY, APPROXIMATELY 50 WILL BE REFERRED FOR A MORE COMPLETE MAMMOGRAPHIC EXAMINATION, WITH ADDITIONAL OR MAGNIFICATION VIEWS.

UNCERTAINLY ABOUT THE NATURE OF THE ABNORMALITY WILL PERSIST FOR 25 OF THESE WOMEN, AND THEY WILL BE REFERRED FOR FURTHER INVESTIGATIONS.

THESE INVESTIGATIONS MIGHT INCLUDE PHYSICAL EXAMINATION, ULTRASONOGRAPHY, AND FINE NEEDLE ASPIRATION WITH CYTOLOGICAL EXAMINATION OF THE ASPIRATE.

IF THE ABNORMALITY IS IMPALPABLE, MAMMOGRAPHIC LOCALISATION IS REQUIRED.

THE DIAGNOSIS WILL STILL BE UNCERTAIN IN APPROXIMATELY 12 WOMEN, AND THEY WILL BE REFERRED FOR SURGICAL BIOPSY.

AGAIN, IF THE SUSPICIOUS LESION IS IMPALPABLE, NEEDLE LOCALISATION WILL BE REQUIRED.

APPROXIMATELY 7 OF THESE 12 WOMEN WILL HAVE BREAST CANCER AND 5 WILL HAVE BENIGN LESIONS.

AT THE CANCER COUNCIL WE ARE VERY CONCERNED ABOUT THE TREATMENT OF THESE 7 WOMEN WITH CANCER.

THE MODEL

TO ACHIEVE SUCH A SCENARIO, THE FOLLOWING MODEL FOR MAMMOGRAPHIC SCREENING AND SERVICE DELIVERY HAS BEEN APPROVED BY THE NSW MINISTER FOR HEALTH.

SLIDE: MODEL

WE HAVE SCREENING UNITS TAKING THE FILMS LINKED TO MULTIDISCIPLINARY ASSESSMENT CENTRES TO WHICH WOMEN WITH ABNORMAL SCREENING MAMMOGRAMS WILL BE REFERRED FOR FURTHER INVESTIGATION.

WOMEN WILL BE REFERRED FROM THE ASSESSMENT CENTRE TO THE TREATMENT CENTRE EITHER BECAUSE THEY HAVE A CYTOLOGICALLY CONFIRMED BREAST CANCER OR A BREAST LESION WHICH REQUIRES OPEN SURGICAL BIOPSY.

FOLLOWING CONFIRMATION OF THE DIAGNOSIS OF BREAST CANCER, RELEVANT STAGING INVESTIGATIONS WILL BE UNDERTAKEN BEFORE RECOMMENDATIONS AND TREATMENT OPTIONS ARE DISCUSSED. THESE MAY REQUIRE CONSULTATION WITH NON-SURGICAL BREAST CANCER EXPERTS, FOR EXAMPLE, RADIATION ONCOLOGISTS AND MEDICAL ONCOLOGISTS.

IN NSW, IT IS ESTIMATED THAT TO COVER THE GEOGRAPHICAL SPREAD OF THE POPULATION OF WOMEN IN THE TARGET GROUPS (AGE GREATER THAN 50) WE WOULD REQUIRE 5-10 ASSESSMENT CENTRES AND 20-30 SCREENING UNITS IN A MIX OF PUBLIC AND PRIVATE SECTORS.

TWO SUB-COMMITTEES OF THE MINISTERIAL ADVISORY COMMITTEE WERE FORMED TO LOOK AT POSSIBLE LOCATIONS FOR SCREENING UNITS AND ASSESSMENT CENTRES.

THE SCREENING UNIT SUB-COMMITTEE WHICH MET FIRST SUGGESTED THE FOLLOWING DATA WOULD BE USEFUL TO INITIALLY RANK THE LOCATION OF SCREENING UNITS (NOT IN ANY ORDER):

SLIDES

- * THE EXISTENCE OF APPROPRIATE EXPERTISE FROM WHICH AN ASSESSMENT CENTRE CAN BE CREATED.

- * THE CAPABILITY IN THE CATCHMENT AREA FOR ESTABLISHING A DATABASE AND MANAGEMENT SYSTEM FOR SCREENING ATTENDEES THAT CAN ALSO BE USED FOR QUALITY ASSURANCE; EG TO LINK IN WITH THE CENTRAL CANCER REGISTRY FOR THE DETECTION OF INTERVAL CANCERS. THE DATABASE CAN ALSO BE USED FOR RECALL OR FOR RESCREENING.

- * THE CAPABILITY IN THE CATCHMENT AREA FOR MOUNTING ADEQUATE HEALTH PROMOTION CAMPAIGNS.

- * THE INCIDENCE OF BREAST CANCER IN THE CATCHMENT AREA.

- * THE NUMBER OF WOMEN IN THE APPROPRIATE AGE GROUP WITHIN EACH CATCHMENT AREA.

- * THE EASE OF ACCESS TO EXISTING CENTRES WITH MAMMOGRAPHIC EXPERTISE FOR TRAINING OF PERSONNEL.

- * A NECESSITY MUST BE A DEMONSTRABLE COMMITMENT TO MANAGEMENT OF A MAMMOGRAPHIC SCREENING PROGRAMME.

THE ASSESSMENT CENTRE SUB-COMMITTEE WAS THEN ASKED TO ASSIST WITH THE IDENTIFICATION OF APPROPRIATE EXPERTISE FROM WHICH AN ASSESSMENT CENTRE CAN BE CREATED.

THE ASSESSMENT CENTRE SUB-COMMITTEE MADE THE RECOMMENDATION THAT THE MOST EFFECTIVE WAY OF IDENTIFYING THE MULTI-DISCIPLINARY EXPERTISE REQUIRED WOULD BE TO CALL FOR EXPRESSIONS OF INTEREST. IN EARLY DECEMBER, THE MINISTER AGREED WITH THIS PROPOSAL AND MANY OF YOU, IF NOT ALL, RESPONDED TO THE ADVERTISEMENT OR FLYER REGISTERING YOUR INTEREST AND SEEKING FURTHER DETAILS. THE MINISTER'S TIMEFRAME REQUIRES THAT THE NECESSARY INFORMATION BE COLLECTED BY QUESTIONNAIRE BY THE END OF JANUARY 1990 AND THAT A SPECIAL ACCREDITATION SUB-COMMITTEE PROVIDE HIM WITH A LIST OF ASSESSMENT CENTRES IN PRIORITY ORDER BY THE END OF FEBRUARY.

ONCE THIS IS DONE WE CAN RETURN TO THE SCREENING UNITS. I THINK IT WOULD BE HELPFUL IF I GO THROUGH THE ENVISAGED ROLE FOR THE ASSESSMENT CENTRES WITH YOU.

SLIDE: ASSESSMENT CENTRE

THERE ARE TWO DISTINCT COMPONENTS TO AN ASSESSMENT CENTRE WITH THE INTERFACE AT THE POINT WHEN A MAMMOGRAM IS DEFINITELY REPORTED "ABNORMAL" AFTER THE RADIOLOGICAL WORKUP. THE WORKUP WOULD INVOLVE RADIOGRAPHERS, RADIOLOGISTS, ULTRASONOGRAPHERS AND, PREFERABLY, COUNSELLORS.

AFTER THIS POINT, THE PERCENTAGE ORIGINALLY RECALLED - SAY 17% IN A MOBILE FACILITY WHERE FILMS ARE NOT DEVELOPED ON SITE - WOULD REDUCE TO APPROXIMATELY 2% AND THESE WOULD PROCEED TO CLINICAL ASSESSMENT. IN A FIXED FACILITY, PERHAPS 10% ONLY WILL BE RECALLED AS IMMEDIATE RE X-RAY MAY RESOLVE SOME QUERY ABNORMALITIES.

A CLINICIAN WOULD BE REQUIRED TO DETERMINE WHETHER THE ABNORMALITY WAS PALPABLE OR NOT. IT IS LIKELY THAT ABOUT 40% OF LESIONS WOULD BE PALPABLE; THE OTHER 60% BEING IMPALPABLE. FINE NEEDLE ASPIRATION WOULD BE PERFORMED ON THE PALPABLE LESIONS BY THE CLINICIAN AND THE RADIOLOGIST WOULD USE THE STEREOTACTIC DEVICE ON IMPALPABLE LESIONS WITH A CYTOPATHOLOGIST REQUIRED TO INTERPRET THE RESULTS. SUBSEQUENT TO THIS, A MULTIDISCIPLINARY COMMITTEE COMPOSED OF CYTOPATHOLOGIST, SURGEON AND RADIATION ONCOLOGIST WOULD AGREE ON A WRITTEN PLAN OF MANAGEMENT. COUNSELLING SERVICES SHOULD MOST DEFINITELY BE AVAILABLE.

NSW APPEARS TO HAVE PROGRESSED MUCH FURTHER THAN THE OTHER STATES IN TERMS OF PLANNING AND OUR MINISTER SEEMS MORE COMMITTED. WE ARE PLEASED WITH WHAT HAS BEEN ACHIEVED TO DATE BUT THERE ARE MANY UNRESOLVED ISSUES WHICH MUST BE SORTED OUT BEFORE PLANS CAN BE CONVERTED INTO ACTION.

A NUMBER OF MEETINGS ARE BEING PLANNED DURING THE NEXT 6 MONTHS, DETAILS OF WHICH ARE STILL TO BE FINALISED. THE CANCER COUNCIL HAS JUST ORGANISED A FULL DAY ON SCREENING SCHEDULED FOR 30TH JUNE AND THE PRELIMINARY ANNOUNCEMENTS WILL BE MAILED NEXT WEEK; MANY OTHERS ARE IN THE PIPELINE.

- DIRECT ACCESS FOR FACE-TO-FACE CONSULTATION WITH OTHER SPECIALIST STAFF WHO MAY BE INVOLVED IN THE MANAGEMENT OF BREAST CANCER. THIS SHOULD INCLUDE CONSULTATION WITH MEDICAL ONCOLOGISTS, RADIATION ONCOLOGISTS, AND OTHER MEDICAL OR SURGICAL SPECIALISTS AS APPROPRIATE. PATIENTS MAY NEED, FOR EXAMPLE, PLASTIC SURGERY CONSULTATION WHEN BREAST RECONSTRUCTION IS PART OF THEIR MANAGEMENT.

- PROVISION OF ALL MAMMOGRAPHY X-RAYS IN THE OPERATING THEATRE.

- PROVISION FOR SURGICAL BIOPSY SPECIMENS TO BE RAPIDLY AND SAFELY TRANSPORTED BETWEEN THE OPERATING THEATRE, SPECIMEN X-RAY SITE AND PATHOLOGY.

- ADEQUATE OPERATING FACILITIES INCLUDING DAY CARE, INPATIENT, LOCAL AND GENERAL ANAESTHETIC SUPPORT.

BEFORE CONCLUDING, I SHOULD TOUCH ON THE THIRD COMPONENT OF THE MODEL - THE TREATMENT CENTRE - WHICH REQUIRES:

- AN EXPERIENCED SPECIALIST BREAST SURGEON TRAINED IN THE USE OF LOCALISATION METHODS FOR SURGICAL BIOPSY AND THE MANAGEMENT OF ALL TYPES OF BREAST PATHOLOGY INCLUDING BREAST CANCER.
- READY ACCESS ON SITE TO MAMMOGRAPHY FACILITIES FOR ACCURATE LOCALISATION OF NON-PALPABLE LESIONS FOR SURGICAL BIOPSY.
- READY AND DIRECT ACCESS TO SKILLED PATHOLOGY.
- PROVISION FOR SPECIMEN X-RAY FOLLOWING LOCALISATION BIOPSY TO ENSURE THAT MAMMOGRAPHICALLY DETECTED LESIONS SUCH AS CALCIFICATION ARE PROPERLY REMOVED.
- READY ACCESS TO SPECIMEN ASSAY FACILITIES FOR BIOLOGICAL MARKERS.

YOUR TWO MAJOR CONCERNS REGISTERED DURING TELEPHONE CALLS REVOLVE AROUND THE PROCESS OF ACCREDITATION AND FUNDING. DISCUSSIONS AND NEGOTIATIONS ARE CONTINUING ON BOTH AND NO-ONE CAN ANSWER MANY OF YOUR QUESTIONS AT THIS TIME. HOWEVER, WHAT CAN BE SAID IS THAT A NEW WAY OF FUNDING PREVENTIVE HEALTH PROGRAMMES IS UNDER ACTIVE CONSIDERATION. IT IS HIGHLY UNLIKELY THAT THERE WILL BE A MEDICARE REBATE NUMBER ASSIGNED TO SCREENING MAMMOGRAPHY. THE MINISTERIAL ADVISORY COMMITTEE HAS PUT SEVERAL OPTIONS TO OUR MINISTER FOR HIM TO DISCUSS WITH DR BLEWETT. ALSO, A TEAM FROM THE AUSTRALIAN INSTITUTE OF HEALTH HAS BEEN DISCUSSING THE ISSUES WITH EACH OF THE STATES.

ACCREDITATION AND FUNDING WILL BE LINKED. IT MAY BE THAT ASSESSMENT CENTRES WILL BE FUNDED ON A CASE PAYMENT BASIS WITH ONE FEE TO COVER SCREENING AND INVESTIGATION. SCREENING UNITS MAY BE CONTRACTED TO ASSESSMENT CENTRES AND PAID A FEE PER NUMBER OF WOMEN-SCREENED WITH INCENTIVES TO MAXIMISE POPULATION REACH.

SO WHAT IS FAVOURED AT THE MOMENT IS A COMBINATION OF CASE BASED AND POPULATION BASED FUNDING.

SCREENING UNITS

ONCE THE IDENTIFICATION OF THE ASSESSMENT CENTRES IS COMPLETE, THEN THE SCREENING UNIT SUB-COMMITTEE WILL DO ITS JOB OF LINKING IN A NUMBER OF SCREENING UNITS TO THE AVAILABLE ASSESSMENT CENTRES.

A SCREENING UNIT CANNOT BE DEVELOPED INDEPENDENTLY OF AN ASSESSMENT CENTRE. THERE MAY BE A VARIETY OF WAYS BY WHICH SCREENING UNITS CAN BE FUNDED. HOWEVER, THE PERFORMANCE OF ALL SCREENING UNITS MUST BE MONITORED AND QUALITY ASSURANCE MUST BE SEEN TO BE OPERATING.

A SCREENING UNIT MUST AGREE:

- (i) TO REGISTER ALL WOMEN HAVING SCREENING MAMMOGRAMS WITH THE STATE BREAST SCREENING REGISTRY;
- (ii) TO PROVIDE A RANDOM SELECTION OF THEIR SCREENING FILMS FOR QUALITY CONTROL;
- (iii) TO FOLLOW GUIDELINES IN RELATION TO FREQUENCY OF RESCREENING;
- (iv) TO DOCUMENT INTERVAL CANCERS.

SCREENING UNITS WILL BE CAPABLE OF SCREENING 5,000 WOMEN PER YEAR AS A MINIMUM.

THAT'S THE MODEL ^{FOR ASSESSMENT CENTRES} BUT WE'LL HAVE TO TEST IT IN THE REAL WORLD BEFORE WE COME UP WITH THE OPTIMAL ORGANISATION OF DESIGNATED ASSESSMENT CENTRES.

THERE MAY HAVE TO BE A TWO-TIER SYSTEM; THE IDEAL BEING BASED ON LARGE METROPOLITAN TEACHING HOSPITALS CAPABLE OF SERVICING 80% OF THE POPULATION, WITH A SECOND TIER INVOLVING SMALLER CENTRES AND PROBABLY SERVICING COUNTRY AREAS.

THE ACCREDITATION SUB-COMMITTEE IS YET TO BE OFFICIALLY AGREED AS ARE THE SPECIFIC CRITERIA BUT THEY WILL BE WITHIN THE PARAMETERS JUST RELATED. NO DOUBT PETER WILSON WILL ADD TO THESE BUT THE SUB-COMMITTEE WILL TAKE INTO ACCOUNT THE VIEWS OF:

ROYAL AUSTRALASIAN COLLEGE OF RADIOLOGISTS

ROYAL AUSTRALIAN INSTITUTE OF ULTRASONOGRAPHY

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

COLLEGE OF PATHOLOGISTS OF AUSTRALIA

NATIONAL ASSOCIATION OF TESTING AUTHORITIES

- TRAINED RADIOGRAPHERS DEDICATED TO MAMMOGRAPHY INCLUDING A MINIMUM OF ONE SENIOR AND ONE JUNIOR RADIOGRAPHER PER ASSESSMENT CENTRE.

 - A MINIMUM OF TWO RADIOLOGISTS TRAINED IN MAMMOGRAPHY, BREAST ULTRASOUND AND LOCALISATION TECHNIQUES.

 - AN EFFICIENT COMPUTERISED DATA BASE TO MONITOR PATIENTS, APPOINTMENTS, RECALLS, RESULTS, OUTCOME, FOLLOW UP AND STATISTICAL ANALYSES.

 - A CYTOTECHNICIAN AND A PATHOLOGIST SKILLED IN INTERPRETING BREAST CYTOLOGY AND HISTOLOGY SPECIMENS, PREFERABLY ON SITE.

 - SPECIALIST BREAST SURGEONS, TRAINED IN THE MANAGEMENT OF ALL ASPECTS OF BREAST PATHOLOGY INCLUDING BREAST CANCER.
- THESE SPECIALISTS SHOULD BE AVAILABLE FOR CONSULTATION AT THE TIME A WOMAN COMPLETES HER RECALL WORKUP, SO THAT THE NEED FOR OPEN SURGICAL BIOPSY AND FURTHER MANAGEMENT CAN BE DISCUSSED AND PLANNED WITHOUT UNREASONABLE DELAY.
- SUFFICIENT STAFF TO MAINTAIN EFFICIENT RECEPTION, FILING AND OTHER CLERICAL AND DATA BASE ACTIVITIES.

IDEALLY, ALL PROCEDURES SHOULD BE COMPLETED ON THE SAME DAY OR AT THE VERY MOST, THE NEXT DAY FOR ALL WOMEN RECALLED. HOWEVER, IT IS ACKNOWLEDGED THAT FOR SOME OUTREACH CENTRES THIS MAY NOT BE POSSIBLE BECAUSE OF LACK OF AVAILABILITY OF EXPERTISE.

ASSESSMENT FINDINGS AND ANY PLANS FOR FURTHER MANAGEMENT NEED TO BE DISCUSSED PERSONALLY WITH THE WOMEN.

RESOURCES REQUIRED

SLIDES

- QUALITY MAMMOGRAPHY EQUIPMENT INCLUDING FACILITIES FOR ACCURATE LOCALISATION AND FNA CYTOLOGY SAMPLING OF IMPALPABLE X-RAY ABNORMALITIES (SPECIFICATIONS TO BE DEFINED BY THE RACR)
- DEDICATED PROCESSING EQUIPMENT (TO BE DEFINED BY THE RACR)
- ULTRASOUND EQUIPMENT (STANDARD TO BE DEFINED BY THE RACR AND THE AUSTRALIAN INSTITUTE OF ULTRASONOGRAPHY).

Susan Hurley

**ANTI-CANCER COUNCIL OF VICTORIA
EDUCATION UNIT**

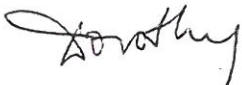
MEMORANDUM

FROM: Dorothy Reading
TO: Breast X-Ray Program Executive, ACCV Mammography Working Party
DATE: 5 February, 1990
SUBJECT: Mammography Working Party NSW policy and plans for mammographic screening

The NSW Cancer Council has appointed Dr Marilyn McMurchie to work on the development and implementation of policy for mammographic screening in NSW.

Attached is a set of papers on this issue which Marilyn left with me on her recent visit to Victoria.

The final paper was presented to an audience of radiographers and radiologists by Elaine Henry, Executive Director of the NSW Cancer Council.



Dorothy

bscdr03r

Memorandum

To: Dorothy Reading, David Hill, Trudy De Luise, Damien Jolley,
Trish Livingston

From: Susan Hurley, Debbie Sytema

Date: October 11, 1989

Subject: Recruitment working party

Copies to: Jill Cockburn

As discussed at the last ACCV working party meeting, a recruitment working party has been convened, and will meet at 10 am Monday 16th October, in Dorothy's office.

Topics for discussion will be

- (1) Plans for the public recruitment campaign, in a standard format, to cover all remaining target areas over the next 12 months.
- (2) Components of the standard campaign, and possible methods of evaluating sub-sets of the campaign.
- (3) A plan for more intensive recruitment in a sub-set of target postcodes:
 - whether to do this
 - if so:
 - which postcode areas?
 - what strategies?
- (4) Plans for personal recruitment (invitation letters, telephone calls), and how these should be co-ordinated with the public campaign
- (5) Targetting women from non-English speaking backgrounds.
- (6) Other!

ANTI-CANCER COUNCIL OF VICTORIA
EDUCATION UNIT

MEMORANDUM

FROM: Dorothy Reading
TO: Professor R. Lovell, Nigel Gray, Robin Marks, David Hill,
Graham Giles
DATE: 17th May, 1989
SUBJECT:

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I attach the notes of a meeting with Dr. Kathy Meade, Secretary of the NH&MRC Health Care Committee, concerning the draft of a position statement for the NH&MRC on a national mammographic screening program.



Dorothy Reading

Anti-Cancer Council of Victoria

Education Unit

Memorandum

Date: 18.4.89

From: Dorothy Reading

To: Professor Lovell, Ian Russell, Susan Hurley

Subject: Arrangements for media content by Breast X-ray program staff.

Attached is Carol Rushford's draft + my re-draft of a proposal to Jonathan Tribe.

Carol has phoned through + accepted the re-draft.

Dorothy

ROYAL MELB HOSPITAL

The Amalgamated Melbourne & Essendon Hospitals



THE ROYAL MELBOURNE HOSPITAL



ESSENDON AND DISTRICT MEMORIAL HOSPITAL

PUBLIC RELATIONS DEPARTMENT

FAX COMMUNICATION

TO: Dorothy Reading
ACCU 663 3412

FROM: Carole Runkra
342 7044 / 7086

(TOTAL NO. OF PAGES including this one)

FAX REPLY NO.: (03) 347 4558

DATE: 14/4/89.

TIME: 2.20 pm

MESSAGE:

Dorothy
Please advise if this proposal is acceptable to you
Regards *Carole*

DRAFT

The results of this recruitment drive will form the basis of advice to government or the acceptability of full screening program in Victoria.

I am writing in regard to the recruitment program for the Breast X-Ray Unit located at the Essendon campus.

Over the next six months a more intensive recruitment drive is planned and a major part of this initiative will involve the co-operation of local print media in the designated areas. /To facilitate this plan I propose that the Education Officer attached to the Unit work with and under the direction of our Public Relations Manager.

In this capacity the Education Officer can directly supply information needed for media releases and utilise the facilities the department offers such as writing and editing copy for press releases, distribution of media releases to defined areas and any other Public Relations assistance that may be required to promote the unit. As well the Public Relations Department would ensure that all parties involved in the unit are kept informed of media contact. It is envisaged that the Education Officer may need to spend up to one or two days a week in the Public Relations Department's office located at The Royal Melbourne Hospital.

I trust this proposal is acceptable to you as a positive step in assisting the program's higher profile objectives.

REF: CLR:rm
25APR89

Dear Carol, I am disappointed to see that your proposal does not

*offer anything that the staff of the Breast X-ray Program are able to supply in-house for press releases & use the services of your department. If merit is to be to work as part of your department she should be able to perform the function not simply utilise them. *They can already achieve.*

FACSIMILE TRANSFER INFORMATION

EDUCATION UNIT
ANTI-CANCER COUNCIL OF VICTORIA
1 Rathdowne Street
Carlton South Vic 3053

to: Fax No.: 347 4558 Date: 18/4/89
Addressee: Carol Rushford No. of Pages:2
PR Dept, AMEH (including this
page)

From: Fax No.: 61 3 6633412
Originator: Dorothy Reading, Education Unit

Dear Carol,

I am disappointed to see that your proposal does not offer anything that the staff of the Breast X-Ray Program cannot already achieve. They are currently able to supply information for press releases and use the services of your Department. However, as I have explained in some detail, this does not meet the needs of the Program and will fall far short of meeting the needs of the intensive recruitment plans for the next six months.

If Meredith is to work as part of your Department she should be able to perform these functions, not simply utilize them.

I attach, for your consideration, redraft of your proposal.

Yours sincerely,



for Dorothy Reading
Director of Education

P.S. I am at home sick and cannot be contacted immediately but Rosemary Collins will get a message to me.

I am writing in regard to the recruitment plans for the Breast X-Ray Program located at the Essendon campus.

Over the next six months a more intensive recruitment drive is planned and a major part of this initiative will involve the cooperation of local print media in the target area. The results of this recruitment drive will form the basis of advice to Government on the acceptability of such screening programs in Victoria.

To facilitate this plan I propose that the Education Officer attached to the Unit work with and under the direction of our Public Relations Manager.

In this capacity the Education Officer can directly supply information needed for media releases, write and edit copy for press releases and distribute these to defined areas and participate in any other public relations assistance that may be required to promote the program.

The PR Department would ensure that all parties involved in the program are kept informed of media contact. It is envisaged that the Education Officer may need to spend up to one or two days a week in the PR Department Office located at the Royal Melbourne Hospital.

I trust this proposal is acceptable to you as a positive step in assisting the Program's intensive recruitment drive.

mamog/lr-1

April 19, 1989

Memorandum to: Dorothy Reading
cc Meredith Giffin

From: Susan Hurley

Subject: Breast X-Ray Program Executive Committee
Meeting - Tuesday April 18

=====

1. Available Appointments

Delia and Ian reaffirmed that there would be 250 appointments per week available from the first week after Easter, April 3. I pointed out that Meredith had obtained information that suggested that 250 appointments were not available in that week and had not been available since. This was disputed. Delia agreed to send to me a breakdown of how the 250 appointments would be distributed through the week and to inform me of any variations to this target number. I am not sure whether this is entirely satisfactory and think we will need to monitor it carefully.

2. Meredith's draft letter to GPs was approved and thought to be a good idea.

3. I passed on the papers regarding your discussions with Carol Rushford to Ian Russell and reported at the meeting that discussions regarding publicity for the program were continuing.

Dorothy,

I think you, Meredith and I need to sort out how we are going to handle this, fairly quickly,

Susan.

SECTION 1 - background data:

Breast cancer is the leading cause of death from cancer in Australian women.

Incidence

About 1600 Victorian women (5049 Australian women) are diagnosed with breast cancer each year.

90% of the cases occur in women aged 40 and over. The lifetime risk of developing breast cancer amongst Victorian women is estimated to be 1 in 14.

Mortality

Approximately 656 Victorian women (2258 Australian women) die from this disease each year.

Risk Factors:

The major risk is increasing age - 90% of breast cancers can be attributed to age.

Other major risk factors are a strong family history (i.e. first degree relative) of breast cancer or a personal history of breast, endometrial, ovarian or colon cancer.
early menarche,
first pregnancy after 30,
late menopause,
diet high in fat and protein,
excessive exposure to irradiation, particularly in adolescence.

These risk factors explain a very small percentage of breast cancer. The major causal factors are unknown.

Prevention and Early Detection

Breast cancer cannot be prevented, given our ignorance about its cause. Consequently the focus has been on early detection since the outlook is best when cancers are detected when they are still small.

Three methods, which should be used in conjunction, can contribute to earlier detection.

- i. Breast self examination (in women over 35).

- ii. Physical examination by trained professional (in women over 35).
- iii Screening Mammography (in women over 50).
No screening methods have been convincingly shown to be effective in younger women.

All these methods are subject to ongoing research.

"Screening mammography" is used on well women (with no symptoms of breast disease) to diagnose breast cancer at a very early stage. The application of screening mammography is currently being piloted in 7 pilot programs in Australia.

Mammography can also be used for "diagnostic" purposes when a woman has symptoms of breast disease. This has been available for some time. A Medicare item number exists so diagnostic mammography is rebatable.

Overseas studies indicate that screening mammography may reduce breast cancer mortality by 30% in women in the 50-69 age group. This has only been achieved in rigidly controlled experimental projects in which 90% of the identified population attended regularly for screening over a period of years. In populations more like our own in health behaviour, e.g. U.K., this degree of benefit has not been shown and is unlikely to occur unless the conditions of the rigidly controlled projects are fulfilled.

In Victoria the best possible outcome of a similar screening project would result in 82 lives being saved (298 lives in Australia) annually if 90% of the 50-69 years population attended for screening every two years for the rest of their lives.

SECTION 2: Current Debate on Mammographic Screening

We have recently seen much discussion in the media and pressure from the community in favour of the immediate setting up of a national mammographic screening program or a Medicare item number for mammography, or both.

The claims that are made seem to fall into three or four major categories, often based on misinformation. I have addressed these below:

1. "The Government must do something now for all women to save somewhere between 0-2000 lives per year."

The potential for saving lives with a national mammographic screening program has been addressed above and is small as I have indicated.

The Government *is* doing something now. Seven pilot programs have been set up across Australia to investigate a wide range of aspects involved with mammographic screening. The most important of these is whether women are interested in being screened, whether they will accept recruitment, and how best to recruit them. The answers are not yet clear.

A variety of other questions are also being investigated.

What is not being investigated is the value of screening mammography itself. It is accepted that this has been demonstrated overseas, that under ideal conditions lives can be saved and there is no need for us to repeat these experiments in a ten year prospective study. The seven pilot programs will screen 15% of women in the 50-69 year age group in Australia so already a very significant proportion of women who stand to benefit are being screened.

The Australian initiative compares well with other comparable countries. It is occasionally claimed, for example, that screening mammography is available in the U.S.A. Nothing could be further from the truth. It is an extremely costly health service available to women who choose to pay the large sums of money involved.

It would not be possible to offer screening now for all women in the appropriate age group in Australia. There are insufficient radiologists (eight year training), radiographers (2-3 years training) currently available to run the services. Many other health services require radiologists and radiographers. They could not reasonably be taken off Casualty Sections of major hospitals, for example, and put on to mammographic screening programs. Furthermore, the work is considered to be extremely boring and not attractive to these skilled staff so that retaining staff in these categories is quite difficult. Gradual introduction of mammographic

screening across the country would allow the necessary increased training of appropriate skilled staff to keep pace with services.

The demand that the Government do something now for all women is based on insufficient information. The only benefit in terms of reduced mortality from breast cancer that has been demonstrated in overseas programs has occurred in the 50-69 year age group. There is some question about the 40-49 year age group and it will be some years before it is clear whether any reduction in mortality can be achieved with this group. These trials continue overseas. There would be no point in repeating them in Australia.

2. "The delay in introducing mammographic screening is simply to save money."

Mammographic screening is expensive but so are heart transplants and liver transplants and many other medical procedures. The money will be found if it can be demonstrated that an equitable service can be delivered at a proper standard.

Mammographic screening seems to be no different from other advances in health care technology. This claim may well be based on the fact that many pilot programs are analysing their work from the point of view of cost effectiveness. It should be understood that cost effectiveness is not measured simply in terms of dollars and mortality. Account also has to be taken of unnecessary procedures engendered by mammography, especially invasive procedures, and "false negatives", i.e. breast cancers that are not picked up by the screening program. The problems of less than perfect mammography include excessive surgical investigation, unnecessary worry in perfectly well women and the occasional wrongly based surgery. We should not proceed with a national screening program until we can be reasonably certain that we can avoid these problems.

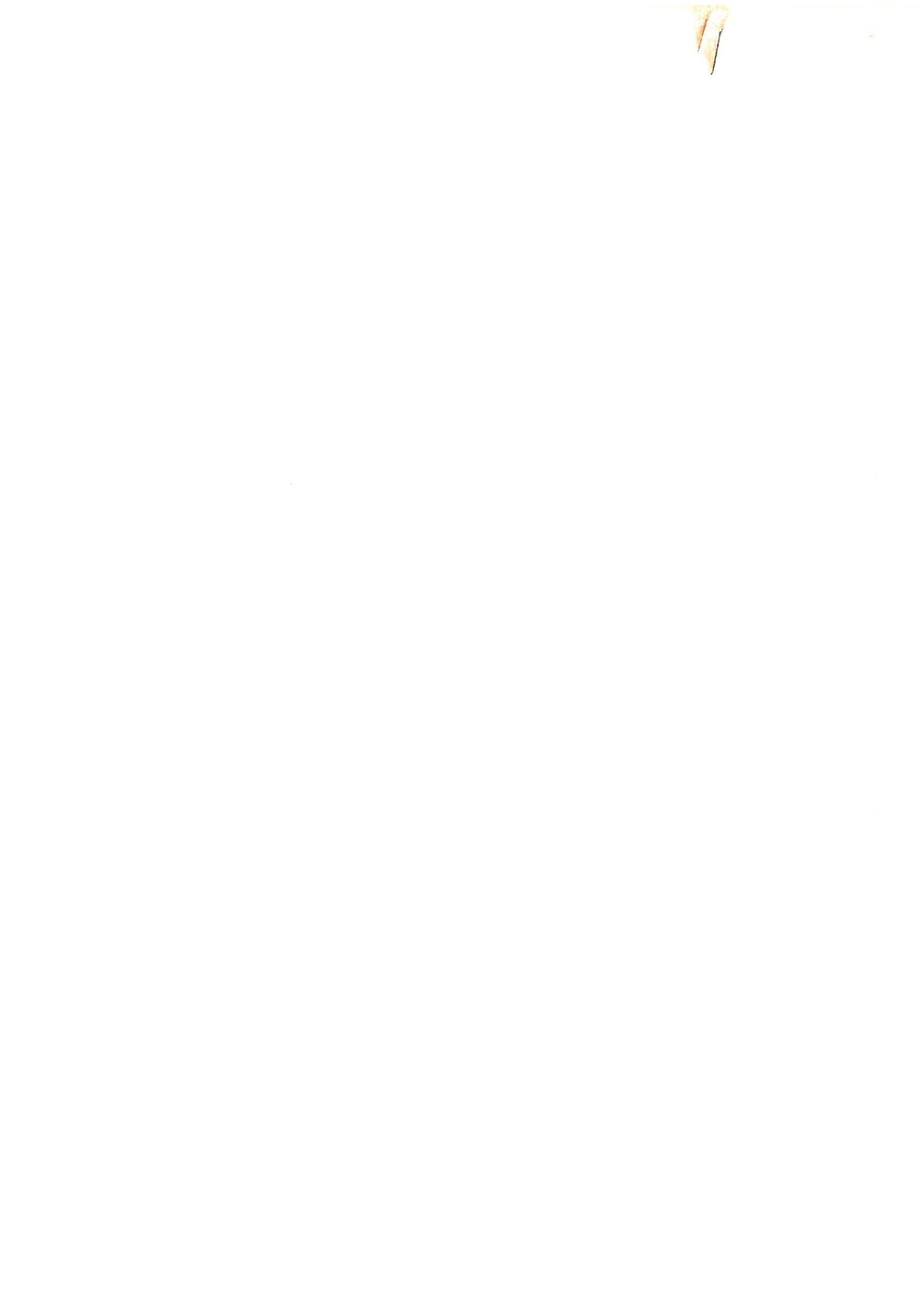
3. A matter not raised in the public debate but worthy of consideration is the question of how breast cancers detected in a mammographic screening program will be managed. They are of a type completely different from those breast cancers that surgeons are currently accustomed to. Our surgical and other medical skills need significant development, based on

clearly developed treatment protocols, before large numbers of very early stage breast cancers can be coped with confidently. There is much inconsistency even in the management of conventionally diagnosed breast cancer, with regard to surgery, chemotherapy, radiotherapy or other treatments.

This problem is being urgently addressed by the Anti-Cancer Council, as is the treatment of minimal lesions likely to be found with screening mammography.

BSRDR01R

10th May, 1989



Anti-Cancer Council of Victoria



57-1r-00b

STATE MAMMOGRAPHIC SCREENING ADVISORY COMMITTEE FOR VICTORIA

TERMS OF REFERENCE

- A. To advise the Minister of Health on the development and coordination of mammographic screening in Victoria, including
- a the design, execution and evaluation of pilot projects
 - b the definition of standards for the performance and interpretation of mammograms, and the standardisation of reporting
 - c the standardisation of the descriptions of pathological findings in lesions detected by mammography
 - d the criteria which should be met by all centres conducting mammographic screening.
- B. To advise the Minister of Health on steps needing to be taken to monitor the effectiveness and efficiency of mammographic screening in Victoria.
- C. 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.
- D. 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.

STATE MAMMOGRAPHIC SCREENING ADVISORY COMMITTEE FOR VICTORIA

MEMBERSHIP

The Director of the ACCV (Dr. Nigel Gray).

Chairperson

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

Executive Secretary

A nominee of the Breast Study Committee of A.C.C.V.

An epidemiologist

A person experienced in behavioural research

A person experienced in public education and health

A nominee of the Royal Australasian College of Surgeons

A nominee of the Royal Australasian College of Radiologists

Nominees of the Minister for Health (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.

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

ACCV MAMMOGRAPHIC SCREENING ADVISORY COMMITTEE (STATE)

MEMBERS

Chairman	Dr NJ Gray Director, ACCV
Executive Secretary	Prof Emeritus RRH Lovell Executive Secretary, VCOG, ACCV
Nominee of Breast Study Cte	Dr RD Snyder Chairman, BSC
Epidemiologist	Dr GG Giles Director, Epidemiology Unit, ACCV
Behavioural Research Scientist	Dr D Hill Behavioural Research Unit, ACCV
Public Education & Health	Ms D Reading Education Unit, ACCV
	Dr R Marks Programs & Management, ACCV
Nominee, RACS	Mr JP Collins
Nominee, RACR	Dr N Sacharias
Nominees, Minister of Health	Ms J Forwoodd Ms J Maddigan
Nominee, Health Department	Ms Onella Stagoll Women's Health Policy Unit
Coopted Member	Mr IS Russell Director, AMEH-ACCV Pilot Project

Committee Members

Deputy Executiv Secretary	Ms Susan Hurley Epidemiologist, ACCV
Administrative Secretary	Ms Susan Fitzpatrick VCOG

Anti-Cancer Council of Victoria



NOTES OF MEETING WITH DR KATHY MEADE (SECRETARY NH&MRC HEALTH CARE COMMITTEE), PROFESSOR R LOVELL AND DOROTHY READING - THURSDAY MAY 4, 1989

**SUBJECT: Draft of position statement for NH&MRC on a National
Mammographic Screening Program**

Dr. Kathy Meade, Secretary of the Health Care Committee of NH&MRC, has been charged with developing a draft position statement for the NH&MRC on this subject, to be submitted to the Council at the end of May. This information was communicated to me by Professor Tony McMichael, who also told Dr. Meade that the ACCV would be interested in discussing her statement and I was able to make arrangements for her to visit us while she was in Melbourne last week.

She brought with her a draft position statement, which she explained was in a very early stage (attached) and we had some general discussion about the background to this topic and the ACCV's interest and involvement in mammographic screening.

Professor Lovell tabled the terms of reference and membership of the State Ministerial Advisory Committee (attached) and gave an explanation of these, indicating that Victoria was very well advanced on both policy development and implementation in this area.

It was clear that there was considerable agreement on basic policy issues between the ACCV and Dr. Meade and that we would have little difficulty in arriving at a position statement that was satisfactory for both parties. I should point out that the role of the ACCV in this process was completely informal, helpful and advisory rather than directive but that Kathy Meade had been directed to consult with interested parties in this way.

We proceeded to go through the draft document in detail and make comments and suggestions on its redrafting. Points that did not appear to be completely covered in Kathy Meade's existing draft were the following:

1. Manpower issues and standards: These two matters are inter-dependent. Mammography is multi-disciplinary so they affect radiologists, radiographers and physical scientists involved with radiation safety monitoring.

The need for special training allowing for accreditation of radiologists was discussed. Professor Lovell gave an outline of the Royal College's guidelines recently developed. The boring nature of the work meant that it could not be assumed that all existing radiologists would be breaking their necks to read mammograms all day.

The need for medical qualifications for reading mammograms was queried, as was the need for fully trained radiographers for performing them.

The shortages of personnel in both radiological and radiographic areas was mentioned.

2. The responsiveness of the population at risk was enlarged upon

The need for widespread community education before recruitment could commence was stressed and the questionable acceptability of such programs to the target population discussed. It was pointed out that there has been a very vocal lobby for the introduction of screening numbers or item numbers for mammography but it is not clear from the pilot programs which are up and running that those doing the lobbying reflect the right age group.

3. Management of breast cancer was discussed. This concern is also held by the NH&MRC and there was agreement that some mention of this issue needed to be included in the position statement.

The idea of breast cancer clinics was aired, with some discussion of the possible load for such clinics in Victoria. The need for recalls and registers to ensure that correct follow-up occurs was raised.

4. There was discussion around the potential to save lives. This could be as low as 90 per annum in Victoria if screening is carried out effectively.

It was agreed that one way to indicate the comparative value to the community of a national screening program would be to indicate the cost of setting up such a program - roughly \$70 million - and the potential number of lives saved. It would be possible for the audience of any position statement to draw its own conclusions about the cost per life saved and compare this with other much needed services in health care.

One interesting point raised by Kathy Meade in her draft is that the currently operating pilot projects will serve approximately 15% of the women in the target age group and that this is a very respectable start to the implementation of a National Screening Program.

bsrdrl lr

10th May, 1989

INTRODUCTION OF SCREENING MAMMOGRAPHY IN AUSTRALIA

Council is concerned at the recent pressure to accelerate the introduction of screening mammography without careful assessment of the optimum design options for a national program for Australia.

~~Overseas studies have indicated the potential for a 30-40% reduction in mortality from breast cancer by mammographic screening. These results were achieved in tightly controlled trial situations. While a number of countries are proceeding to implement national screening programs no country has a fully operational program as yet. The process of establishing and evaluating pilot projects which will operate as centres of excellence is the first step in implementation of a national program. This evaluation process does not preclude their progressive expansion. These centres will serve as training centres for staff required for a national program. Overseas experience endorses this process of progressive expansion from centres of excellence.~~

new para →

at least 20% of the population are likely to be screened in a program

~~The 30-40% reduction in mortality has only been achieved for the age group 50-69 years. This age group accounts for 55% of deaths from breast cancer in Australia each year. Outside this age group mammography has not yet been shown to significantly reduce mortality.~~

less than half

~~Many issues need to be addressed in order to achieve the maximum potential benefit from a National program.~~

- These include: ^{strategies for recruiting women into screening}
1. ~~Recruitment Strategies.~~ Those which have been successful overseas (such as call from a register) may not be acceptable to Australian women. Further it is important that as far as possible screening should be equally available to all sections of the population.
 - 6 Availability of skilled personal. A high level of expertise in screening techniques is required to minimise the possibility of a mammogram giving false reassurance by failing to detect a cancer and to minimise unnecessary investigations and surgery for lesions which are benign. Sufficient skilled personal are not available at present to implement a national program.
 - 7 Availability of the highly specialised services required to assess and treat abnormalities detected by screening. Such services are not readily available throughout Australia.
 - 2 ^{Protocol} Strategies to ensure that women are appropriately followed up if an abnormality is detected.

Visual lobby for introduction of pilot prog. that they are numerous.

Equity

+ registers



- 3 The optimum frequency for screening.
- 4 The role of screening outside the age group where benefit has been demonstrated.
- 5 Quality control of all steps in the screening program₃ ^{+ sub-type of}
- 8 Development of services which meet the needs of disadvantaged groups e.g. the role of mobile units in rural areas.
- 9 The roles of the public and private sector in a National program.

Currently operating pilot projects which are part of the evaluation studies are serving approximately 15% of the 1.4 million women in the age group 50-69 years.

Implementation of a national screening program will be a costly exercise. Value for money will only be achieved by implementing a high quality, cost-efficient and integrated program.

Council endorses the current strategy of careful evaluation of pilot projects and staged introduction of mammographic screening in an integrated program, which ensures high quality services which are acceptable to women ~~of~~ breast health.

Tony
my fax no is 062 897802 if you
would like to make some comments.
Cathy Mead

ANTI-CANCER COUNCIL OF VICTORIA

EDUCATION UNIT

MEMORANDUM

FROM: Dorothy Reading
TO: Onella Stagoll, Nigel Gray, Sheila Hirst
DATE: 17th May, 1989
SUBJECT: Notes for brief session on breast cancer and mammographic screening

=====

Very brief notes outlining important background data on breast cancer and comment on media and community pressure on mammographic screening are attached.

These notes will be used to brief Onella Stagoll, Co-ordinator Women's Health Unit, Health Department of Victoria, and others she may care to nominate, such as the Minister for Health, other bureaucrats and parliamentarians.

Dorothy Reading



NOTES FOR BRIEFING SESSION FOR ONELLA STAGOLL

SECTION 1 - background data:

Breast cancer is the leading cause of death from cancer in Australian women.

Incidence

About 1600 Victorian women (5049 Australian women) are diagnosed with breast cancer each year.

90% of the cases occur in women aged 40 and over. The lifetime risk of developing breast cancer amongst Victorian women is estimated to be 1 in 14.

Mortality

Approximately 656 Victorian women (2258 Australian women) die from this disease each year.

Risk Factors:

The major risk is increasing age - 90% of breast cancers can be attributed to age.

Other major risk factors are a strong family history (i.e. first degree relative) of breast cancer or a personal history of breast, endometrial, ovarian or colon cancer.

- early menarche,
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- excessive exposure to irradiation, particularly in adolescence.

These risk factors explain a very small percentage of breast cancer. The major causal factors are unknown.

Prevention and Early Detection

Breast cancer cannot be prevented, given our ignorance about its cause. Consequently the focus has been on early detection since the outlook is best when cancers are detected when they are still small.

Three methods, which should be used in conjunction, can contribute to earlier detection.

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SECTION 2: Current Debate on Mammographic Screening

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The claims that are made seem to fall into three or four major categories, often based on misinformation. I have addressed these below:

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programs. Furthermore, the work is considered to be extremely boring and not attractive to these skilled staff so that retaining staff in these categories is quite difficult. Gradual introduction of mammographic screening across the country would allow the necessary increased training of appropriate skilled staff to keep pace with services.

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This problem is being urgently addressed by the Anti-Cancer Council, as is the treatment of minimal lesions likely to be found with screening mammography.

BSRDR01R

10th May, 1989