

Keeping Abreast special feature insert:

Screening women from culturally and linguistically diverse (CALD) backgrounds in SA.

In SA, the overall screening participation rate for CALD women is marginally lower than the rate for all women. Details include:

- screening participation rates and re-screen rates for CALD women vs all women.
- Screening participation rates for language groups with more than 500 women aged 50-69.

Mammographic screening for women aged 40-49

This information is based on BreastScreen Australia's National Information Statement entitled **Breast Cancer Screening for Women Aged 40 to 49** (February 2003):

Age is the biggest risk factor in developing breast cancer. Around 75% of all breast cancers occur in women over the age of 50.¹

Current research shows that mammographic screening is most effective in detecting early breast cancer in women aged 50-69. Evidence of the benefit for women aged 40-49 is less clear, and is currently not strong enough to encourage all women in this age group to have regular screening mammograms.

Younger women tend to have more dense breasts mammographically, and so the screening mammogram is a less sensitive test for early breast cancer than in women over 50.

In addition, younger women who have screening mammograms are more likely to be called back for investigation of abnormalities that prove to be benign.

Based on current evidence, the decision to start mammographic screening while a woman is still in her 40s should be based on individual factors including her family history and personal risk of breast cancer.

It is important for all women to be aware of the look and feel of their breasts. Symptomatic women should have diagnostic mammography and/or ultrasound, and the principles of triple assessment should be applied (see *Keeping Abreast*, No 3, March 2003).

BreastScreen Australia will continue to review its screening policy for women aged 40-49 as new evidence becomes available. Although they are not specifically targeted to attend, women in their 40s who have no breast symptoms are welcome to have free screening mammography through BreastScreen Australia.

1. *Australian Institute of Health and Welfare (2000) BreastScreen Australia Achievement Report 1997 and 1998. AIHW Cat No CAN8. Canberra: Australian Institute of Health and Welfare (Cancer Series Number 13).*

Inside this issue:

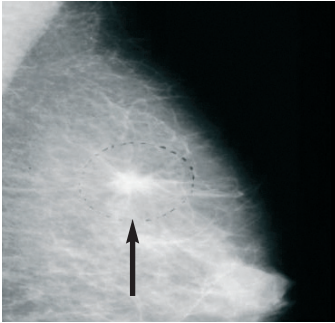
The treatment of early invasive breast cancer	2
BreastScreen SA's CALD Recruitment Campaign	4
Strategies for General Practitioners	4

Diary note: Australia's Breast Cancer Day (ABCD) Monday 27 October 2003

Please encourage your female patients aged 50 to 69 to call BreastScreen SA on 13 20 50, to make an appointment for their free screening mammogram.

Appointments are available at six clinics in metropolitan Adelaide, and three mobile units visit 27 country regions and some metropolitan areas every two years, the recommended screening interval. For clinic locations and mobile unit visit details, see the BreastScreen SA website at www.breastscreen.sa.gov.au

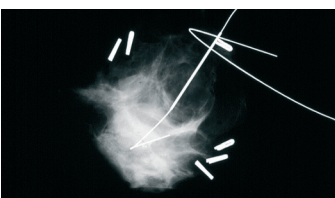




Above: Small cancer shown on screening mammogram.

Screen-detected breast cancers are more likely to be less than 15mm in size and node negative.

The aim is to establish a diagnosis prior to surgery.



Above: Specimen x-ray with hookwire.

The treatment of early invasive breast cancer

Breast cancer remains the commonest form of cancer and the leading cause of cancer deaths in South Australian women. However, the introduction of screening mammography and advances in the management of breast cancer have led to the age-standardised death rate decreasing by approximately 20% among women aged 50 to 69 years.¹

Early detection of breast cancer has had an enormous impact on its management. It has been accompanied by significant changes and advances in diagnostic and surgical techniques, as well as other major aspects of treatment.

This article discusses the treatment of early invasive breast cancer; for information about ductal carcinoma in-situ, see *Keeping Abreast, Number 2, Sept 2002*.

Characteristics of screen-detected breast cancers

Cancers detected by screening mammography are more likely to be small (ie less than 15mm) and have less nodal involvement than symptomatic cancers.

Around 20% of mammographically detected breast cancers are node positive, compared to 59% of symptomatic tumours,² while 57% of screen-detected cancers are impalpable.

Diagnosis

The aim is to establish a diagnosis prior to surgery, and minimise the need for diagnostic open biopsy. Triple assessment, involving correlation of imaging, clinical and where necessary needle biopsy results, is applied to screen-detected breast abnormalities at BSSA's Assessment Clinic.

It is particularly important in a mammographic screening program that unnecessary investigations in healthy women are minimised.

Core biopsy

Fine needle aspiration biopsy and cytology are well established diagnostic procedures. To make a definite diagnosis prior to surgery, core biopsy is often also required.

This is done under local anaesthetic, using a larger needle, with ultrasound or mammographic guidance of needle placement for accurate sampling. At least 80% of women with breast cancer have the diagnosis established prior to surgery, allowing pre-operative staging and discussion of treatment options. Frozen section is now rarely required.

Treatment

The management of breast cancer optimally involves a multidisciplinary team consisting of radiologist, surgeon, pathologist, oncologist, general practitioner and counsellor.

Surgical management

The two main options for surgical management of breast cancer are total mastectomy and partial mastectomy.

Partial mastectomy requires complete removal of the cancer with a surrounding margin of normal breast tissue, while preserving cosmesis. This is combined with radiotherapy to the residual breast tissue to reduce the risk of local recurrence.

To determine whether a patient with breast cancer is a candidate for conservative surgery, several factors need to be taken into account:

1. Tumour size.
2. Tumour location.
3. Presence or absence of multicentric cancer.

Absolute contraindications to breast conservation surgery and irradiation include pregnancy, a history of prior radiotherapy to the breast region, and persistent positive margins after surgery and re-excision(s).

Patients should be given a full explanation of options, benefits and risks. Factors to consider include long-term survival, risk of recurrence, and psychological adjustment.

The goal of surgery is complete removal of suspicious and malignant tissue with minimal cosmetic deformity.

Localisation

Non-palpable lesions need to be localised prior to surgery to enable accurate removal of the abnormal area. When required following fine needle aspiration biopsy, localisation is done at BSSA's Assessment Clinic using carbon ink, usually under ultrasound guidance. Core biopsy sites need time to heal before localisation can be done, and this is usually arranged by the treating surgeon prior to surgery. Pre-surgical localisation may also be done using a hookwire rather than carbon.

Specimen x-ray

Intra-operative specimen radiography should be performed for all non-palpable lesions to confirm that the mammographic lesion has been excised. Correlation with the pre-operative mammogram is required.

Management of the axilla

The pathological status of the axillary lymph nodes is the single most important prognostic factor and helps to determine treatment recommendations. Partial or complete surgical axillary clearance is required to determine nodal status in invasive cancer. This can result in significant morbidity with lymphoedema, restricted shoulder mobility and subjective arm symptoms.

Sentinel node biopsy

Only 20% of women with screen-detected breast cancer have nodal metastases and so 80% may have unnecessarily extensive axillary surgery. To address this issue, sentinel node biopsy is being evaluated in an attempt to obtain accurate staging with minimal arm morbidity.

This technique involves mapping the nodes which directly drain the cancer using lymphoscintiscanning. One or two sentinel nodes are removed and subjected to extensive pathological sampling.

Sentinel node biopsy is suitable for women with small cancers, clinically negative nodes and no previous axillary surgery. Studies to date indicate that sentinel lymph node biopsy accurately predicts the status of the whole axilla in 97% of cases. Clinical trials are continuing.

Margins

Successful local excision requires that the cancer is completely excised with a surrounding clear margin of normal tissue. Pathology examination of the surgical specimen therefore includes assessment of the margins, and further surgery may be needed if the margins are not clear. Women should be warned of this possibility.

Treatment following surgery

A multidisciplinary approach is essential with correlation of imaging, pathology and surgical findings, and close cooperation with radiation and medical oncologists. Radiotherapy can begin once the patient has healed from the surgical procedure (usually six weeks).

Adjuvant treatment is offered to women who are considered to be at high risk of relapse based on tumour size and grade, receptor status and axillary lymph node status. Systemic adjuvant treatments include hormonal manipulation and chemotherapy and are introduced early in an attempt to eradicate micrometastatic disease.

Long-term care

Survival after breast conserving surgery and radiotherapy is equivalent to that following mastectomy. There is a 1% per annum risk of local recurrence. Regular follow-up by a breast specialist is required to allow early detection of recurrent or new cancer and to identify treatment sequelae. Annual clinical assessment and breast imaging are essential. More detailed investigations are required for symptomatic patients, but are not warranted for routine surveillance as there has been no proven benefit.

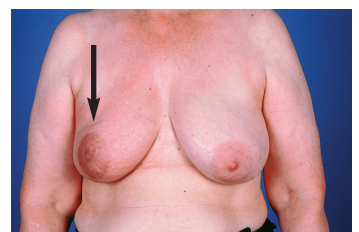
1. *Epidemiology of Cancer in South Australia. Incidence, Mortality and Survival 1977 to 2001.* Cancer Series no 24. Department of Human Services, South Australian Cancer Registry, 2002.
2. Gill PG, Luke L, Farshid G, Roder, D. *Mammographic detection: an independent prediction of outcome in early breast cancer.* The Breast (in press).

The assistance of Professor PG Gill, Surgical Coordinator, BreastScreen SA, and Dr S Pieterse, Pathology Coordinator, BreastScreen SA, in preparing this article is gratefully acknowledged.



Above: Localising the sentinel node:
 - check with gamma probe over skin mark
 - make incision over marking
 - locate afferent blue lymphatic and trace to the node.

Pre-operative localisation and intra-operative specimen radiography are essential for all non-palpable lesions.



Above: Cosmetic result after breast conserving surgery (arrow indicates scar).

BreastScreen SA's CALD Recruitment Campaign

BreastScreen SA's recruitment campaign for women from culturally and linguistically diverse (CALD) backgrounds includes the following components:

1. Employing a CALD Project Officer who is responsible for the development and implementation of the CALD recruitment campaign, and for the provision of information and resources on breast cancer screening to CALD women, health workers and community workers.
2. Consulting and collaborating with key CALD community representatives and CALD workers.
3. Distributing brochures in 16 languages.
4. Arranging female interpreters at no cost, to assist women on the phone, and at the screening and assessment visits.
5. Organising informal CALD advisory groups.
6. Communicating via the ethnic media.
7. Conducting presentations in a range of languages.
8. Conducting information seminars/ meetings for CALD workers.
9. Implementing the CALD Small Grants Strategy, in which CALD groups apply for grant funding to conduct activities, which include a breast cancer screening education/recruitment component.
10. Participating in special events, such as setting up displays at national days, cultural festivals etc.

For further information contact Ms Jelena Poljak-Fligic at the Cancer Council South Australia, or Ms Karen Shepherd at BreastScreen SA (contact details at right).

For further information and to order translated brochures contact:
Ms Jelena Poljak-Fligic
CALD Project Officer
The Cancer Council South Australia
Phone: (08) 82914168
Fax: (08) 82914268
Jelena is available Mon to Wed during business hours.

Ms Karen Shepherd
Promotions & Education Manager
BreastScreen SA
Phone: (08) 82747102
Fax: (08) 83734395

For more information please contact:

Medical Officers
BreastScreen SA
1 Goodwood Road
WAYVILLE SA 5034

Phone: (08) 8274 7150
Fax: (08) 8357 8146
Email: info@breastscreen.sa.gov.au

WE'RE ON THE WEB
www.breastscreen.sa.gov.au

Strategies for General Practitioners

Building collaborative partnerships with General Practitioners is an important strategy for BreastScreen SA.

We offer:

- a range of free printed resources, including stickers with which to tag the files of your female clients over age 50.
- seminars for health professionals and practice managers – at BreastScreen SA or your venue.
- a Clinical Audit Activity developed by BreastScreen SA's Medical Officers.
- screening participation information for GPs.
- personalised contact with GPs via surgery visits.
- display materials.
- articles for professional magazines/newsletters.

Contact our Medical Officers for more information.

Information in this newsletter is not a substitute for seeking appropriate specialist advice in individual clinical situations.