



Features

Chroniques

Lynne Cohen is a freelance writer living in Nepean, Ont.

Can Med Assoc J 1997;157:442-4

FPs have vital role in ensuring success of breast cancer screening programs

Lynne Cohen

In brief

SCREENING IS THE ONLY PROVEN STRATEGY for reducing breast cancer mortality in women older than 50. Over the last 9 years, 8 provinces and 2 territories have established independent dedicated mammography programs. A recent workshop on screening programs was told that family physicians play a crucial role in the ultimate success of these programs because of their referral role.

En bref

LE DÉPISTAGE EST LA SEULE STRATÉGIE ÉPROUVÉE de réduction de la mortalité causée par le cancer du sein chez les femmes de plus de 50 ans. Au cours des neuf dernières années, huit provinces et deux territoires ont créé des programmes indépendants de mammographie. À un atelier récent sur les programmes de dépistage, on a affirmé que les médecins de famille jouent un rôle crucial dans la réussite ultime de ces programmes, parce que ce sont eux qui ont pour rôle d'envoyer les patientes au dépistage.

Family physicians have a “critical” role to play in organized breast cancer screening, doctors attending a recent national workshop on the screening programs were told. “Not only does the GP know each woman in his or her practice and when it is time for her to go for screening, but the doctor is also well situated to steer screening patients into the organized programs instead of to smaller mammography units in local hospitals,” said Dr. Sue Aitken, a medical oncologist and provincial director of the Ontario program.

Aitken was one of about 35 doctors who spoke during the workshop, which was organized under the auspices of the National Committee for the Canadian Breast Cancer Screening Initiative (NCCBCSI). The committee, created in 1993, helps develop organized screening programs and facilitates the flow of information among them. The workshop, which brought together 300 screening proponents from Canada, Australia and England, was billed as the first opportunity for personnel from all Canadian programs to exchange ideas.

The primary goal of all programs is a reduction of breast cancer mortality; currently, death occurs in about 31% of all diagnosed cases. Second only to lung cancer as a cause of cancer mortality in women, breast cancer eventually affects 1 in 9 Canadian women.

It is most treatable when detected early, a fact recognized by British Columbia in 1988 when it introduced Canada's first organized screening program. Its establishment came on the heels of several large international randomized control trials, which revealed that early mammographic detection of malignant breast tumours in women aged between 50 and 69 years can reduce mortality significantly.

Even though screening programs now exist across the country, Aitken said many doctors fail to use them. “Physicians are reluctant to change referral patterns,” she said in an interview. “They tend to refer patients to a health centre in the community that does mammography, and to the local people they know. Many doctors don't understand what provincial breast cancer screening programs are about — they think we are going to take over patient care, which is completely



Dr. Susan Aitken: physicians reluctant to change referral patterns



wrong. We want to streamline things for everyone involved, provide quality assurance and give the doctor back all the information we get. The doctor absolutely continues with the care of the patient.”

She insisted that doctors need to learn about and understand the benefits of organized screening. “A main benefit is quality control, which is very standardized and closely monitored inside the programs. We are able — through training and testing — to ensure the best possible mammogram and the highest degree of skill in reading it.”

The programs, which cost up to \$6 million a year to run, are also specially organized to track and recall patients, so that recalls are automatic. “Screening once in a while or once in a lifetime is not going to reduce a woman’s mortality risk,” she said. “Screening has to be done every 2 years, as a regular part of health care.”

The centralized programs do provide for more thorough data collection. The Canadian Breast Cancer Screening Database (CBCSD), established in 1993 in response to the growing desire to compare and contrast data from different programs, has already revealed some interesting national trends.



Dr. Heather Bryant: screening programs at different stages of development

For example, in its preliminary report — produced in collaboration with the NCCBCSI, Health Canada, 7 provincial screening programs and the Yukon Mammography Program — CBCSD documents the 1994–95 recruitment success of programs in British Columbia, Alberta, Saskatchewan, Ontario and Nova Scotia. Only Saskatchewan screened more than half its targeted population (53%), while Ontario screened only 10%, or 47 540 women. The goal of most programs is to screen 70% of the target population; goals aren’t set higher because of problems related to geography and resources.

“The breast-screening programs are at very different stages of development,” said Dr. Heather Bryant, chair of NCCBCSI and director of the Division of Epidemiology, Prevention and Screening of the Alberta Cancer Board. “Some of them, like British Columbia’s, are quite well established.

Others have just started up, and programs in Quebec and Prince Edward Island are planned and will start up soon. Some programs have more experience than others in mobile delivery, for example, or in recruiting hard-to-reach

Education, testing crucial for successful mammography screeners

Introducing better ways to test and train radiologists in mammography remains an ongoing challenge, but 2 promising projects were demonstrated during the recent National Workshop on Organized Breast Cancer Screening Programs in Ottawa.

Cupido Daniels, a professor of radiology at Dalhousie University and head of the Diagnostic Medical Physics Division at the Queen Elizabeth II Health Sciences Centre in Halifax, has developed a series of radiology CD-ROMs, including one entitled *Fundamentals of Breast Imaging*. “This is the only one of its kind in Canada,” he said in an interview, “and I have had excellent feedback on it.”

The computer program provides instruction on several related topics, including epidemiology, reading a mammogram, quality assurance, pathology, male breasts and case studies. It allows students to learn at their own pace and does not take limited teaching time away from clinical staff. The CD-ROM is now available commercially.

Dr. Paula Gordon, a radiologist with British Colum-

bia’s Screening Mammography Program, demonstrated that program’s standardized mammography reading test for screeners. “No other province has this test,” she said. “To work in our program, a radiologist must be reading a minimum number of mammograms per week, and pass this test.”

Comprising a mixture of 100 actual breast films, the test requires doctors to distinguish healthy tissue, cancerous tissue and abnormal benign tumours. “The test is designed to measure a radiologist’s sensitivity — the ability to find cancer when it is present — and specificity — the ability to read the film accurately,” explained Gordon. “If you read 100 films and recall all 100 women, your sensitivity is considered very high because you have not missed any cancers. But you have caused enormous anxiety in all the healthy women, so your specificity is zero. You want to keep your call back rate as low as possible.”

To pass the test, radiologists’ sensitivity score must be above 85%, and specificity above 65%.



Canada's screening programs for breast cancer

Physicians can contact breast cancer screening programs in their region.

Yukon: 403 667-8738; 403 393-6620

Northwest Territories: 403 669-4111 x4110

British Columbia: 604 660-3636

Alberta: 403 220-4302

Saskatchewan: 306 359-0550

Manitoba: 204 788-8633

Ontario: 613 724-7999

Quebec (starting September 1997): 418 646-2063

New Brunswick: 506 453-2283

Nova Scotia: 902 473-3960

Newfoundland and Labrador: 709 738-4772

women. Some offer clinical breast examination on site and some offer services to women outside the target populations."

However, Bryant said all programs share the same diagnostic features. They all target women aged 50 to 69, screen each woman at 2-year intervals and offer 2-view mammography, meaning that 4 films are produced during every screening. They are primarily administered through publicly appointed bodies.

The question of whether to include women aged 40 to 49 in screening programs remains highly controversial. "It has been shown that mammographic screening leads to a 15% decrease in the breast cancer mortality rate of women in that age group," said Dr. John Boyages, director of the New South Wales Breast Cancer Institute in Australia. "This is not enough of a benefit to offer screening to this age group. However, these are the women in Australia who are the loudest in their demands for screening because they are the most health conscious. It is probably the same in Canada."

It is, agreed Aitken, who added that there are additional excellent reasons for excluding this group. "For one thing, there is a lot of difficulty visualizing breast tissue in younger women, though improving technology may soon change this situation. But there remains the problem that the tumours in women between 40 and 49 grow more quickly, so we would have to screen annually. Also, since this is the baby-boomer group and therefore huge in absolute numbers, the programs would probably have to more than triple in size and budgets to accommodate them. And in the end, the younger women really are not at that great a risk."

Aitken said research into virtually every aspect of

breast cancer — from biology to psychology — has expanded appreciably in recent years. "Women's groups complained bitterly in the past about lack of attention to breast cancer," said Aitken. "Though there is still a way to go, they have gotten their wish."

Since 1995, more than 25 studies have received 5-year grants totalling \$20 million from the Canadian Breast Cancer Research Initiative, which is operated by the Medical Research Council of Canada and 3 other national health groups.

Dr. Nicholas Perry, director of the Central and East London Breast Screening Service in England, said screening programs face unique problems, including prohibitive travelling distances for patients, a lack of screening data and insufficient coordination and training of screening professionals. However, he maintained that the biggest problem involves the failure of GPs to recruit patients for the programs.

"It is vital to all breast-screening programs that more GPs get involved," said Perry. "We can't just send mammogram results to the women. GPs are well placed to be the greatest promoters of organized breast screening." ?

CALL FOR PAPERS

1998 INTERNATIONAL CONFERENCE
ON PHYSICIAN HEALTH

MANAGING OUR OWN CARE: SURVIVING THE HEALTH CARE REVOLUTION

APR. 29 – MAY 2, 1998
VICTORIA, BC

Abstracts are invited for consideration as part of the 1998 International Conference on Physician Health, sponsored by the Canadian Medical Association, the American Medical Association, the Federation of Licensing Authorities of Canada and the Federation of State Physician Health Programs.

Presentations dealing with any aspect of physician health, including issues of well-being, impairment, disability, treatment and education, will be considered for poster presentations, paper sessions and workshops.

The deadline for abstract submission is Oct. 31, 1997. For information and an abstract submission form contact: Elaine Tejcek, American Medical Association, Physician Health Program, 515 N State St., Chicago IL 60610; tel 312 464-5073; fax 312 464-5841; elaine_tejcek@ama-assn.org

ASSOCIATION
MÉDICALE
CANADIENNE



CANADIAN
MEDICAL
ASSOCIATION