This year marks the twentieth year since the formation of the ACT and SE NSW Breast Cancer Treatment Group. The group formed after the publication of the first Clinical Practice Guidelines for Management of Early Breast Cancer in 1995. The inaugural meeting was convened by the ACT Chief Health Officer and included interested professionals and consumers who collaborated to review and improve clinical outcomes for those diagnosed with breast cancer in our region. This ambitious and innovative project was designed to implement the recommendations of the clinical practice guidelines into routine practice.

The improvement in the proportion of breast cancer patients receiving evidence-based surgery and adjuvant treatments over time (as summarised in the group’s 15-year report) is proof of the ongoing impact that the founding members had in saving the lives of people diagnosed with breast cancer. I am still in awe of how the big idea of the Quality Assurance Project became a reality and how it is still going strong after 20 years!

We have enjoyed excellent speakers in 2016 at the Group meetings with Dr Trish Pulvirenti presenting on Deep Inspiration Breath Hold Technique in radiotherapy, and Dr Bruce Littlefield who provided an informative explanation of the development and mechanisms of a breast cancer drug from the bench to the bedside. Thanks to Dr Jonathan Rice who prepared a presentation of the Cancer Australia statement on the 12 practices identified as appropriate or inappropriate for the provision of breast cancer in Australia.

Of course, all of the accomplishments listed would not have been possible without the voluntary contribution of general practitioners, clinicians treating breast cancer, practice managers and our breast care nurses. The high quality of the data and participation rate is attributable to Yanping Zhang and her team, Thet Khin and Jenny Green. Thank you!

I would like to thank ACT Health for ongoing support of this project as well as the Radiation Oncology Private Practice Fund for the annual donations over the last several years. Thank you to the consumer representatives from Breast Cancer Network Australia and Bosom Buddies for your expertise and valuable contribution to our meetings. We look forward to the ongoing collaborations with the National Breast Cancer Audit and the Breast Cancer Tissue Bank project.

As a group we look forward to the next 20 years and exploring ways in which we can continue to improve the lives of our breast cancer patients.

Dr Angela Rezo
Radiation Oncologist
Chair, ACT & SE NSW Breast Cancer Treatment Group
DATA MANAGEMENT SUB-COMMITTEE CHAIR’S REPORT

The Data Management Subcommittee continues to meet regularly to monitor the data collection and consider applications for use of the data, in addition to the primary use of providing a community based audit of breast cancer care and outcomes of treatment for the region. We approved a number of research projects ranging from the examination of the risk of relapse to the incidence of weight gain during treatment.

We continue to provide personalised feedback to our contributing clinicians. In addition, the project is providing feedback data generated by our participating surgeons to assist them with compliance with their professional obligations to provide audit data to the Breast Surgeons of Australia & New Zealand (formerly the Breast Section of the RACS).

This year the subcommittee has been able to take stock after the completion of the 15 year Report. I would like to thank the subcommittee members who gave up their time to assist with the management for the project, particularly after the strain of producing a comprehensive report. They are all busy people, and their support is crucial. This year we were joined by Dr Hai Phung from the ACT Cancer Registry on the sub-committee. We look forward to continuing collaboration with the registry.

The longevity of the data collection is a great strength, allowing a longitudinal view of breast cancer care. There is a down side however. Although progressing well, the data collection project team remains under pressure because of the increased number of subjects requiring ongoing follow-up. The follow up schedule was changed several years ago to rely on passive follow-up of subjects 15 years beyond the time of diagnosis; however the number of subjects in active follow-up continues to rise. For new enrollees, challenges remain in obtaining the necessary information, and also in securing consent forms. Despite these difficulties the team led by Yanping Zhang continues to produce high quality results. I thank her and her colleagues Ms Thet Khin and Ms Jenny Green for their great contribution. The subcommittee is very grateful for significant support from donors and in particular the Radiation Oncology Private Practice Fund for the ongoing extra support.

Many clinicians including surgeons, GPs, oncologists, breast care nurses, and practice secretaries have contributed data and assisted in providing consent documentation to potential participants. Without their help the project would not have been possible over such a long period. Finally, I would like thank all of the women and men who have trusted us to collect and safeguard their private information.

A/Prof Paul Craft
Medical Oncologist
Chair, Data Management Sub-Committee

A MESSAGE FROM THE DIRECTOR, BREASTSCREEN ACT

Congratulations again on another very successful year, even though it has not been without significant challenges. We now have over 6,800 recorded cases of breast cancer in the ACT and surrounding region, and as usual, Yanping and her team diligently pursue every notified case to gain consent and to ensure accuracy of data collection, entry, and reporting.

At the recent BCTG meeting we celebrated reaching the milestone of 20 years since the group was formed. Who would have thought the program would still be going, especially when it was initially funded for a 12 month period! The ongoing success of the project is directly attributable to Yanping, her team, and of course the commitment of the clinicians and all who provide data.

We are entering a very exciting phase of the project as we are in our 20th year of data collection and collation. I urge all clinicians to obtain as many completed consent forms as possible, both for newly diagnosed clients and for those we may have previously missed.

Thank you all for your continued support for this very valuable project. Wishing you and your families a very happy and safe Christmas and festive season.

Yvonne Epping
Director BreastScreen ACT
Cancer, Ambulatory and Community Health Support
Canberra Hospital & Health Services
The BCTG Quality Assurance Project began the 20th year of data collection in July 2016.

- **Graph 1** shows how the number of patient records progressively increased since a second administrative position was created in July 2000. We have struggled to seek small amounts of funding to obtain casual staff assistance for many years.

- **Graph 2** illustrates that the majority of patients are willing to participate over nearly 20 years of the consent process, but some do miss out being informed about the project.

**For patients:** please contact your treating doctor to sign the consent form.

Clinicians’ voluntary contribution is important. Participating clinicians are in the best position to obtain patient consent.

**For clinicians:** a little contribution could make a huge difference.

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**A MESSAGE FROM THE DIRECTOR, RADIATION ONCOLOGY ACT**

I would like to congratulate the Chair of the Breast Cancer Treatment Group, Committee Members and of course what feels like a lifetime of effort from Yanping Zhang and her team. This is a milestone of 20 years of service to ACT and Regional NSW Breast Cancer Patients. The dataset collected by BCTG represents a unique opportunity for cancer research along with opportunities for clinicians to standardise treatments for our patients. The data also promotes excellence in therapy and patient outcomes and as a consequence we now can validate these efforts with evidence. The Radiation Oncology Private Practice Fund sees the investment in this long term initiative as productive and worthwhile so that outcomes and research can prosper in the Territory. We also acknowledge past contributors (some fallen) and our colleagues for coming together in this wonderful moment.

**A/Prof Hany Elsaleh**
Radiation Oncologist
Director of Radiation Oncology

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**THANK YOU!**

Radiation Oncology Private Practice Trust Fund

We would like to thank the Radiation Oncology Private Practice Trust Fund for their generous funding to support the BCTG Quality Assurance Project 2016/2017. This support will facilitate and augment the continuing valuable work of the project and better expand its ability to provide high quality data for clinicians, and serve as a basis for further studies and publications.

— Breast Cancer Treatment Quality Assurance Project Team
I have the pleasure of working with an excellent team of breast surgeons at Calvary Hospital, ACT. This job is part of the first year of my Post Fellowship Training in Breast Surgery, a position I obtained through the centralised process coordinated by BreastSurgANZ.

Apart from being involved in the surgical management of breast cancer patients, I am conducting a research project under the supervision of Dr Usama Majeed. Dr Angela Rezo and Dr Majeed, have been extremely supportive of my research. After submitting an application, I was very lucky to gain access to the ACT & SE NSW BCTG database. Obtaining information from this dataset has been a really efficient process thanks to the help of Yanping Zhang, the Project Manager. The objective of my research is to evaluate the risk of additional non-sentinel lymph node metastasis in patients with metastatic sentinel lymph node biopsy, according to intrinsic subtypes of breast cancer.

The management of the axilla in breast cancer patients has greatly evolved in the last decade. However there are still controversies, especially regarding the identification of patients who benefit from axillary treatment in the form of axillary radiotherapy, axillary dissection or both. Furthermore, in the last decade gene expression analysis has challenged the view that breast cancer is a single disease. Four molecular subtypes of breast cancer have been identified, each one having a particular clinical behaviour and response to treatment. Surrogate definition of these molecular subtypes (intrinsic subtypes), can be obtained using immunohistochemistry evaluating the expression of ER, PR and HER2. Preliminary results of this study were presented at the ACT Annual Scientific Meeting in November 2016. We expect to present the final results in an International Breast Conference and also publish the results in a peer review journal.

Dr Grace Tapia Novoa
Breast Fellow
Calvary Health Care Hospital (ACT)

The Breast Cancer Treatment Quality Assurance Project has been collecting data and examining the outcomes of breast cancer treatment in the ACT & SE NSW region for over 19 years. Almost 7,000 participants have been enrolled since inception of the Project in 1997. It has become progressively more significant as a data resource for the study of breast cancer management and survivorship outcomes. Primary data is collected from the region’s breast surgeons and is central to the BCTG project. Data is subjected to strict quality assurance resulting in a comprehensive and reliable database and as such is an invaluable source for the National Breast Cancer Audit (NBCA).

The National Breast Cancer Audit is a Royal Australasian College of Surgeons (RACS) initiative, originally conceived by the RACS in 1998. Focus is on quality control and quality improvement via the collection and analysis of audit data, to improve the surgical care and management of people with breast cancer in Australia. This collected performance data is monitored against pre-defined Australian and international standards, enabling continuing education and quality improvement activities. There are many other benefits to breast surgeons including professional development and recognition as a quality assured breast surgeon.

The Breast Cancer Treatment Quality Assurance database by nature of its data collection has since 2001 produced required data annually on behalf of the region’s breast surgeons for submission to the NBCA. It is a convenient and expedient way for breast surgeons in the region to have their individual and confidential breast cancer data submitted to NBCA.

It is my privilege as the Project Officer assigned to assist Yanping to ensure the data is of high quality prior to submitting these reports. Data submitted to NBCA is unidentifiable and cannot be submitted until outcome is known, hence it is important to provide full and correct data in the correct format and at the correct time. Admittedly this can be time consuming, especially when information is missing or incorrect, however having a detective-like task suits my style well. I quite enjoy following an information trail to achieve the right conclusion. Even a simple matter of missing tumour size can take quite some time. Feedback received from BreastSurgANZ Quality Audit (BQA) once the data is uploaded and passed through testing shows that our attention to detail was worth it.

It is rewarding to achieve continuous improvement of the database. Quality control is our top priority.

The annual report for the BQA to the Royal Australasian College of Surgeons was completed in October 2016, on schedule, on behalf of six BCTG participating breast surgeons.

Jenny Green,
Project Officer, BCTG
According to local radiologist, Dr Jeremy Price, while breast MRI is now well-established as an extremely sensitive screening test for breast cancer, we should be cautious not to provide false reassurance to the subgroup of women who carry BRCA1 mutations.

Speaking at a 4-day conference in Sydney in August 2016, alongside a distinguished international faculty which included renowned experts (‘Mammo’) Mike Linver and Gilda Cardenosa from the USA, Jeremy Price reviewed the available data on MRI screening of BRCA mutation carriers during a session with the theme “Focus on MRI”.

“We now have follow-up data from organised screening programs which have been going on for at least a decade. So instead of relying on surrogate endpoints like tumour size and stage, we can actually see how women who have opted for secondary preventive measures are faring.

The key point is that it’s not enough just to find the cancers early, we have to prove that we can offer an effective intervention. This has been a concern with regard to BRCA1 mutation carriers because with the advent of molecular pathology we know that 80-90% of the cancers we find in this subgroup are the highly-aggressive triple-negative basal-like cancers. The problem with this tumour type is its propensity to metastasise early by haematogenous spread and is often node-negative. When we looked at our local albeit small number of cases, we found that of 6 cancers in BRCA1 women, 4 were interval cancers which had presented as clinical lumps between annual screening rounds. Review of the previous MRIs confirmed these as normal. Essentially this means that the screening did not work because the cancers had developed so rapidly. Worse still, one BRCA1 woman with invasive cancer found on her second MRI screening round, who then opted for bilateral mastectomy, subsequently developed distant metastases and died about 8 years later. That is clearly a disastrous failure of screening.”

“Studies from other centres told a similar story”, Jeremy told the conference attendees. “The Dutch MRISC group found that of 11 interval cancers they had encountered, 10 were in BRCA1 carriers while 9% of BRCA1 women had metastases at 9 years follow-up. Similarly a study from Norway of 802 BRCA1-affected women reported 10-year survival of only 69% and even for stage 1 cancer, 5-year survival was only 82% compared to the expected 98% in the general population.

The position is completely different for BRCA2 carriers where locally we had 8 cancers detected with MRI screening and no interval cancers. Data from Norway showed 10-year survival of 100% in the MRI-screened BRCA2 group.

I would say that Angelina Jolie made a very good choice. Based on available evidence, it makes sense to offer primary prevention with prophylactic mastectomy to the BRCA1 subgroup as soon as women are comfortable with making this decision.”

Dr Jeremy Price
Radiologist
It was the best of times; it was the worst of times. Well no, it wasn’t the best of times. Diagnosing cancer is one thing I like least about my job. Despite the improvements in outcomes, a cancer diagnosis is scary. Patients fear surgery and have heard horror stories of chemotherapy. Their initial distress is such that they often don’t hear anything I say after I give the diagnosis. I encourage a family member or support person to attend the appointment, but that person is often upset as well.

Cancer management is one of the few areas where GPs don’t share care with the specialist during treatment and treatment can last for months or years. Over that time the patient and GP can lose touch with each other. With other conditions, the GP may not be involved in the care for a short period of hospitalisation, but then continues to support the patient. For example, a patient may be admitted for chest pain, have an angioplasty, continue to see the cardiologist after discharge and participate in cardiac rehabilitation, but will still see their GP for secondary prevention and prescriptions. When a patient is diagnosed with breast cancer, they are referred for surgery, chemo and/or radiotherapy. There is no routine GP follow up visit. A patient may drop in to see their GP to complete paperwork for sickness benefits or ask for a prescription for Ondansetron, but it is the exception rather than the rule. I’m not advocating that patients should see GPs for the sake of it. Patients have usually had enough of doctors and hospitals and the last thing they want to do is see another doctor on their days off from chemotherapy. But it has an impact. GPs add most value, when they know their patient over time, when they understand and have supported the patient and their family through their trials and tribulations.

I diagnosed three patients with breast cancer in close succession. One was well known to me because I saw her regularly for her diabetes. The second came to the surgery often with her children, though not for herself. I didn’t know her well, but she trusted the clinic. The third didn’t have a GP and had been referred by BreastScreen when they diagnosed her cancer. Over the years since the diagnosis, I continued to see the first patient for her diabetes and she would ask me to translate what the oncologist and radiologists told her, not always easy as she would often see me before the letter had arrived. I helped with her mood, her family relationships and her pain. After receiving a letter of notification telling that the latest round of chemotherapy had failed, I told her of her grim prognosis. I don’t know if she wasn’t told or didn’t hear, but she hadn’t realised things were so bad. It was a sad but uplifting consultation with tears from both her and her daughter salvaged with humour planning a bucket list.

The second patient did better clinically, but I didn’t see her regularly. She saw me to complete paperwork, but rarely for health issues. But while I didn’t feel like I knew her well, she saw me as her doctor. She would see other doctors for minor ailments because their waiting times were shorter, but when it was something important such as when she found another lump, she saw me.

The third patient I only met a couple of times. I’m not sure if we didn’t click or if she didn’t like GPs or just saw GPs as superfluous to her management, but she didn’t come back to me or the surgery.

The relationship between cancer patients and their GP is variable. GPs provide longitudinal, holistic care. The relationship is the key. The better the relationship between the patient and their GP, the more value we can add. If cancer treatment isn’t successful, not all patients need the technical skills of the palliative care specialists. But if a patient doesn’t have, or has lost contact with their GP, it can be hard to build up the rapport and trust needed to provide this service. These patients are likely to end up in the stretched specialist service, leaving fewer services for those who need more advanced palliative care skills.

Please encourage your patients to keep in contact with their GP during their cancer treatment especially as the first port of call for non cancer health issues.

Dr Marianne Bookallil
GP Advisor
ACT Health Directorate
In my years in general practice, I have seen several women in their 80s or 90s with a palpable breast lump which, on investigation, has proven to be malignant. Some of these women have had advanced disease with palpable axillary nodes, and the chance of cure is low. Others have had small tumours which are potentially curable. Almost invariably, their preference has been not to have surgical treatment, on the basis that they are “so old”. They often seem very fatalistic and willing to accept that their breast cancer may kill them. However, many of them ARE fit for surgery and could be cured (usually if you get to 90 you have at least a 10 year life expectancy). In addition, I do not think women have a concept of the awfulness of locally advanced ulcerating disease. They also don’t appreciate how LONG it may take for their breast cancer to kill them.

In some of these women, hormonal therapy has slowed tumour growth or caused regression for some time, but the tumour has “escaped” therapy eventually. There is then a decision in an even older patient about having surgery. Some patients have opted for this and done really well.

I have referred all these patients to an oncologist, and often a surgeon (despite their insistence that they do not want surgery), but I do feel uncomfortable about not treating a curable cancer. I am sure other GPs would also appreciate some discussion of this age group of cancer patients, and of the management of their likely clinical course and symptoms.

Dr Tracey Baker
GP at Chapman Family Medical Practice
CONSUMER REPRESENTATIVE’S PERSPECTIVE – A VOICE FROM A LONG STANDING BCTG MEMBER

Congratulations to the Breast Cancer Treatment Group (BCTG) on your commitment to best practice. This was clearly demonstrated in the 15-year report from the Breast Cancer Group Quality Assurance Project. Despite funding problems, the Tissue Bank continues to provide valuable research material. Guest speakers update knowledge and skills but also provide a great opportunity for me to learn about new treatments.

Since 2007, I have passed this information to the local ‘breast cancer community’ emailing a regular e-newsletter BCNACTION update, a Dragons Abreast Canberra newsletter and research updates, to other local groups and individuals. I also write a BCTG meeting report for Breast Cancer Network Australia (BCNA).

Personally, I felt on a roller coaster when diagnosed with breast cancer in 2001. However, having learnt through BCTG about the major improvements and developments in targeted therapies, new drugs and protocols, when my older sister was diagnosed with breast cancer in 2015 I felt well able to assist her during her treatment.

Breast Cancer Network Australia (BCNA) works to ensure that Australians affected by breast cancer receive the very best support, information, treatment and care appropriate to their individual needs. BCNA provides the free BCNA “My Journey Kit” for early breast cancer and the “Hope & Hurdles” packs for metastatic breast cancer. BCNA is represented by the pink lady silhouette, symbolic of our focus on the women diagnosed with breast cancer and all those around them.

I recently participated in Cancer Australia’s Consumer Training Workshop for the Priority-driven Collaborative Cancer Research (PdCCRS). All that I have learnt from the BCTG meetings equipped me well for this challenge.

I feel privileged to attend the meetings as a Consumer Representative for Breast Cancer Network Australia (BCNA) and wish to thank all members for their continued dedication to the care of their breast cancer patients.

Kerrie Griffin
Breast Cancer Network Australia (BCNA) consumer representative

THE AUSTRALIAN BREAST CANCER TISSUE BANK

The Australian Breast Cancer Tissue Bank Project in Canberra has been running since 2009. The central management hub is at the Westmead Millennium Institute in NSW and there are 10 affiliate sites across Australia. A National Breast Cancer Foundation National Infrastructure Grant was awarded this year to continue the central operations. As of November 2016, 7716 have been recruited onto the Australian Breast Cancer Tissue Bank project with 891 of these participants from our region. The ACT collection centre have been continually funded by research grants from the Radiation Oncology Private Practice Trust Fund since 2012 to continue tissue collection activities.

Elaine Bean from ACT Pathology is the local Tissue Bank Officer responsible for processing of biological samples and maintaining the database. Rowena Penafiel has been working with the Breast Cancer Treatment Group to keep the update the treatment data from 2014 to 2016. Ramesh Shanmugasundaram will take over this role in 2017.

www.abctb.org.au

Professor Desmond Yip
Medical Oncologist
Principal Investigator, Australian Breast Cancer Tissue Bank
ACT Collection Centre
The Breast Cancer Treatment Group (BCTG) is an important group of specialists, health care professionals and health consumers that has existed in Canberra for more than 19 years. In 2015 Bosom Buddies Inc celebrated its 20th birthday. 20 years of providing support to people in the ACT & the surrounding region who have been diagnosed with breast cancer. Bosom Buddies has been a health care consumer representative on the BCTG for many years.

The Bosom Buddies BCTG representatives are Kaye Johnston, Coordinator of the Hospital Visiting and Support Team (HVST), and Di Summerhayes, member of HVST, both long time members of Bosom Buddies. Kaye and Di share the attendance at the meetings and report back to the Bosom Buddies Management Committee on issues of interest to our membership.

Di was diagnosed with Breast Cancer for the first time in December 1994 - and treatment was lumpectomy, radiotherapy and chemotherapy. It was all such an impact for someone who didn’t know anyone at that time who had breast cancer. A second diagnosis was made in August 2003 that resulted in bilateral mastectomies and once again chemotherapy. By this time Di had been involved in Bosom Buddies for nine years and kept up to date with current issues relating to breast cancer and its diagnosis. And at the same time Di was attending some of the BCTG meetings.

Kaye was diagnosed in 2001 shortly after being posted to Perth from Canberra. At Kaye’s very first mammogram at WA BreastScreen detected an area of concern which proved to be ductal carcinoma in situ (DCIS) in the very earliest stage. Despite the early diagnosis, further testing showed that a right mastectomy was necessary, but the good news was that Kaye was a suitable candidate for an immediate TRAM reconstruction. On return to Canberra, Kaye was referred to Dr John Buckingham for her ongoing care – it was Dr Buckingham who suggested Kaye might get in touch with Bosom Buddies for support – she did just that and has stayed involved ever since.

Like Di and Kaye, all of the Bosom Buddies HVST have experienced Breast Cancer and are available to support others.

Bosom Buddies is honoured to participate in the BCTG as a consumer representative. Our attendance at the Group meetings allows us to hear interesting presentations by specialists, researchers etc. that we would not usually have access to. The presentations are varied and always cover topical issues. It is also a wonderful networking opportunity for us.

Di Summerhayes & Kaye Johnston
Bosom Buddies ACT Inc

ACKNOWLEDGEMENTS

2016 is another milestone of Breast Cancer Treatment Group (BCTG)! It marks the 20th Anniversary, since the group was formed. Next year, 2017, we will be celebrating the 20th Anniversary of the Quality Assurance Project. This Group is establishing more and more, year by year, because of the helping hands! We would like to thank all the participants for the generous contribution of their precious time, and hard work in assisting with the completion of Data Collection and Follow Up. Special thanks to all the surgeons, the oncologists, the medical receptionists, general practitioners, practice managers, practice nurses, all breast care nurses, administrative staff, radiologists, BreastScreen ACT, ACT as well as NSW Registries of Births, Deaths & Marriages, Bosom Buddies, Breast Cancer Network Australia, a large number of pathologists such as from ACT Pathology and Capital Pathology and Breast Cancer Tissue Bank Project Team. Finally, we acknowledge Eisai, AstraZeneca, and Novartis for sponsoring the Breast Cancer Treatment Group meetings and also thanks to Lyn North and staff at University House, ANU for providing the venue and resources for our meetings.
**March**

Dr Trish Pulvirenti presented “Deep Inspiration Breath Hold Radiotherapy for Breast Cancer”. Dr Pulvirenti discussed the data showing the relationship between radiation dose to heart and cardiac morbidity and mortality. She described the DIBH technique, the benefits and the implementation of DIBH in Canberra.

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**July**

Dr Bruce Littlefield, Global Oncology Medical Affairs, Eisai, from Massachusetts, USA was introduced by Dr Mile Janevski. Dr Littlefield presented “Eribulin mechanisms of action: Beyond antimitotic effects to complex changes in tumour biology”. Dr Littlefield presented the work he has done throughout his career in the development of Eribulin. He presented an eloquent and informative discussion about the mechanisms of this drug - both anti-mitotic effects and complex non-mitotic effects including effects on the microvasculature, reversal of mesenchymal phenotype and reducing the cancer cell’s potential to metastasise.

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**November**

On behalf of Dr Jonathan Rice, foundation member of the BreastSurgANZ subspecialty group of the Royal Australasian College of Surgeons, Michelle McMahon presented “Influencing Best Practice in Breast Cancer” with 12 statements including genetic counselling, assessing of pathological specimen, biomarkers, discussing fertility and family planning, discussing different surgical options, types of radiotherapy, continuity of support and care, options for palliative care, options of neo-adjuvant and other systemic therapies, long term and standard follow up.

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**The Quality Assurance Project (QAP): Achievements and Challenges**

At the November BCTG meeting, Yanping Zhang summarised some achievements made by the BCTG in its 20-year history, especially the success of the QAP. However, the project faces several challenges. The clinician participation rate remains high, but their heavy workload has prevented them from being more involved in data collection. This has increased our reliance on alternative ways of data gathering, which may undermine the project’s future success.
**BCTG JOURNAL PUBLICATION**

*IHC4 score plus clinical treatment score predicts locoregional recurrence in early breast cancer.*
Roopa Lakhanpal, Ivana Sestak, Bruce Shadbolt, Genevieve M. Bennett, Michael Brown, Tessa Phillips, Yanping Zhang, Amanda Bullman, Angela Rezo. The Breast, Volume 29, issue, Oct 2016, Pages 147-152

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**BCTG MEETING ON 14TH NOVEMBER 2016**

From Left to right – Sanjiv Jain, Lesley Calvert, Lauren Deaves, Bethel Holly, Vicki Matthew, Anne Bicknell, Kerrie Griffin, Geraldine Robertson, Susan Bell, Robin Stuart-Harris, Michelle McMahon, Jeremy Price, Andreea Ardeleanu, Desmond Yip, Jane Twin, Linda Warwick, Angela Rezo, Elizabeth Webb, Suet Wun Chen, Paul Craft, Jane Dahlstrom, Elizabeth Chalker, Thet Khin, Jenny Green, Kaye Johnston, Lyn North & Yanping Zhang

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**BCTG MEETING DATES FOR 2017**

6th March 2017 (Monday)

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24th July 2017 (Monday)

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13th November 2017 (Monday)

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Paul Craft cutting the cake at November BCTG meeting
Any clinical questions should be directed to Dr Paul Craft at the Canberra Hospital on (02) 6244 2220.

**Project Co-ordinator/Data Manager**  
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