Breast Cancer Treatment Group Report from the Chair

Dr Angela Rezo
Radiation Oncologist
Chair, ACT & SE NSW Breast Cancer Treatment Group

The Breast Cancer Treatment group has been meeting and conducting quality assurance activities for more than 16 years! Novel initiatives from the project office have meant that the participation rate is still greater than 95% – a credit to the hard-working team at the Project Office especially, but also to the clinicians involved in the project, their support teams, breast care nurses and of course, the ongoing support of our patients. The number of women and men with breast cancer registered on the quality assurance project exceeds 5400 and the mean follow up is currently 6.5 years. The number of women who have also consented to have their de-identified data and tissue collected for the Breast Cancer Tissue Bank exceeds 580.

The strength of our data and the uniqueness of this Project cannot be understated! The high participation rate, the prospective collection of tumour, patient, treatment, and outcome data, and the relatively uniform treatments delivered by a limited number of cancer specialists means that the data is extremely high quality.

Next year will see the publication of the 15 year report. The purpose of the five-yearly reports is to assess treatment delivery against best practice and to observe outcomes that can be benchmarked against national and international reports. The way we embrace and deliver evidence-based medicine will be assessed and for the first time a comparison of outcomes over time intervals can be conducted as part of the quality cycle.

During the first meeting of the year, strategic direction was discussed. This was an opportunity to discuss our achievements to date and to consider our future. One of the challenges identified is how we will measure our delivery of survivorship care which is becoming an increasingly important with the large proportion of breast cancer survivors in our cohort. This objective may be achieved with BCTG collaborations with proposed survivorship clinics and shared-care follow programs that are currently being explored.

At our second meeting we had the pleasure of listening to the Calvary Breast Cancer Fellow Dr Saifulla Syed and Dr Usama Majeed speak about advances in oncoplastic breast cancer surgery – a very engaging and informative talk! The last speaker of the year, Prof Afaf Girgis gave a fascinating presentation of Survivorship issues and her own research projects in this field. Collaborations with researchers such as Prof Girgis could potentially improve outcomes for the large number of individuals surviving breast cancer in our community. Understanding how we can measure and improve these non-binary outcomes will be a challenge for our group, but one that would be supported by our consumers. Psychosocial, lifestyle and dietary translational research in breast cancer is a growing and evidence based practice in these domains is very likely to have a large impact on our patients.

Our general practitioners continue to provide the bulk of follow-up information and appreciate that with the good outcomes for our patients and the ever-growing database, this is no easy feat.

The ongoing and generous support from the Radiation Oncology Private Practice continued into 2013/2014 financial year. This allowed the employment of Mary-Claire Tryon who conducted extremely valuable auditing activities.

The dedicated project office team has continued to support the breast surgeons in providing information to the National Breast Cancer Audit and also supporting the Breast Cancer Tissue Bank. We congratulate project officer Thet Thet Khin on the birth of her baby boy and we welcome Jennifer Green who has made the role her own in a short period of time. We were also fortunate to have very competent temporary employees who filled in for Thet earlier in the year – Peta Flynn and Marion Rose. The professionalism and commitment to maintaining a high-quality, ethical and comprehensive database by the whole group, especially Yanping Zhang should be applauded!

Finally, I would like to welcome members of the BCTG to consider how the database can be utilized to increase our understanding of breast cancer. The scientific subcommittee welcomes all investigators but especially those that contribute to the group’s activities.

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Report from the Chair of the Data Management Sub-committee

I would like to congratulate the team led by Yanping Zhang over the past 16 years that the project has been collecting, correcting and collating data describing the breast cancer treatment and outcome in the region. I strongly endorse the thanks from our Chairperson to the staff contributing to the project this year.

The longitudinal nature of the project and its durability are now becoming very important attributes. A study published by members of the Group this year on surgical margins and local recurrence is detailed elsewhere in the Newsletter. This study is an example of the value of these data. The results help to clarify the surgical margin that should be considered adequate, informing our own practice, as well as the wider community about this technically important area. The information will lead to less re-excisions being required after breast conserving surgery for invasive breast cancer.

The coming year is shaping up as a very important and busy period for the data collection project team. We have some ongoing or planned studies based on the data collection, looking respectively at metastatic disease, male breast cancer, and patterns of chemotherapy use. Most importantly we will be providing a 15-year report of the project. This will continue the series of detailed reports presented each 5 years. One of the big issues in cancer care, and in medicine in general, is to be sure that the benefit of treatments promised by clinical trial results is reflected by the same favourable outcome in routine practice, particularly as viewed across a region. The forthcoming report, incorporating up to 15 years of follow-up data, will offer us a unique perspective of treatment effectiveness outside of the artificial environment of the clinical trial. The durability of the project is the key feature in this endeavour. The report will be a lot of fun to prepare, and I invite all members who are interested to join in the preparation and review of the manuscript during 2014.

Finally I would like to offer my thanks to the men and women who have generously given permission to have their treatment information included in the project. We are particularly sensitive to issues of privacy. Protection of the privacy of information included in the data collection has always been a priority for the team. Most importantly the project could not be successful without the support of our clinicians: surgeons, oncologists, breast care nurses and general practitioners, who help us every day by providing the precious information that the project is built upon. This support all the more remarkable in that it has persisted undiminished for 16 years.

THANK YOU!

To the Radiation Oncology Private Practice Trust Fund for their generous funding to support the BCTG Quality Assurance Project in 2013/2014. This support will facilitate the continuing valuable work of the project and allow it to expand in its ability to provide high quality data for clinicians, and as a basis for further studies and publications. This unique data set will allow clinicians to make decisions to shape the way breast cancer treatments develop by investigating trends indicated by the extensive data, and the extra funding allows for extra capability in terms of meticulous auditing and data preparation which is crucial to this project. We rely on such extra generosity to “go the extra mile”.

A/Prof Paul Craft
Medical Oncologist
Chair, Data Management Sub-Committee
16 Years of data collection: preliminary results

The Breast Cancer Treatment Quality Assurance Project has now been running successfully for more than 16 years. To date, 5,400 newly diagnosed breast cancer cases have been notified to the Project, with 95% of patients agreeing to have their information included on the Project database.

Graph 1 shows that the number of new cases from the ACT and SE NSW have been growing steadily since 2000. Graph 2 shows that the majority of invasive cancer cases have been ductal or mixed ductal with most tumours ranging between 11 to 50 mm.

Graphs 3 and 4 indicate the trends in post-operative adjuvant treatment. Specifically, Graph 4 shows the sharp increase in the use of Anthracycline and Taxane in recent years.

Table 1 shows that 16 years after the Project commenced, around three-quarters of patients are alive and disease free, and 6.5 years mean follow up for the first 15 years of this study will be analysed. Further results will be presented in the 15-year report. For more details relating to the results please contact Yanping Zhang (yanping.zhang@act.gov.au).

You may contact Dr Angela Rezo (angela.rezo@act.gov.au) or Dr Paul Craft (paul.craft@act.gov.au) if you are interested in being involved with the preparation of the 15-year report.

Table 1: Patient outcomes after 16 years of follow up

<table>
<thead>
<tr>
<th>Current status</th>
<th>Number of patients</th>
<th>Percent of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alive, disease free</td>
<td>1,493</td>
<td>75.2%</td>
</tr>
<tr>
<td>Alive with disease</td>
<td>63</td>
<td>0.3%</td>
</tr>
<tr>
<td>Deceased due to breast cancer</td>
<td>275</td>
<td>14.7%</td>
</tr>
<tr>
<td>Deceased due to other causes</td>
<td>194</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>2,025</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Note: Including only female patients with invasive breast cancer, with surgeries performed between July 1997–Jun 2007. The data exclude 371 cases current status unknown and 15 cases where the cause of death is unknown.
The Breast Cancer Treatment Quality Assurance Project Picture

Tom Roberts’ painting of the opening of the first federal parliament on 9th May 1901, “The Big Picture”, shows the detail of each and every face present in the crowd that day. Each and every ‘face’ of the many, who contribute to the work of the BCTG Project, is the detail which creates the “Big Picture”.

These include the general practitioner, the surgeon, the specialist, the oncologist, the pathologist, the medical receptionists, practice staff and many more.

With this in mind, we explored some of the ‘detail’ - our colleagues each and every one, who form the Big Picture that is the Breast Cancer Treatment Group Project.

Painting a picture - from the Surgeon’s Rooms

Dr Ian Davis’ Rooms

Dr Ian Davis commenced his general surgery practice in Canberra in 1993. As a compassionate and dedicated surgeon he and his caring and committed staff have successfully provided person-centred comprehensive and continuing health care for 20 years.

The first of Dr Davis’ patients to consent to participate in the Breast Cancer Treatment Project was in April 1997. Over the following years, more than 1,200 patients have agreed to participate.

In 2010 Dr Davis also became involved with The Breast Tissue Bank Project with 240 patients enrolled by November 2013.

Many additional hours have been contributed by Dr Davis and his staff to ensure that each patient has treatment as soon as possible. Twelve hour days are often the norm. This enables additional patients to be seen. If surgery is required within just a few days, there is a great deal of administrative organisation e.g. theatre times, rescheduling patients etc. This is only possible with the wonderful support from hospital booking staff, theatre staff, anaesthetists, assistants, breast care nurses, oncologists and radiotherapists; all willing to go that extra mile to ensure that patients have the best treatment at a time in their lives that is most confronting.

Patients are asked after consulting with Dr Davis regarding their treatment and as part of the arrangements for surgery, whether they are happy to participate in the Breast Cancer Treatment Group and Tissue Bank projects. It is often at a time when everything is very overwhelming. Most patients are very pleased to participate as they would like to know that in some way they may be of help to others. Thanks also to Yanping Zhang and the Project team members for the many hours they put in to ensure the project continues to be of benefit.

Michele Dunstone
Secretary for Dr Ian Davis, Surgeon

Dr Jonathan Rice’s Rooms

The diagnosis of Breast Cancer can be a great shock to a patient and their family; however it is only the first step on what can be a very long road. The logistical issues for regional patients can be a great challenge however we are very lucky to have access to great surgeons and the willingness of Canberra oncologists to travel to regional centres makes this road a little easier to travel.

One of the largest logistical challenges faced by patients in regional areas is that of radiation oncology. With radiation oncology only being available in larger centres this puts a considerable strain on our patients and their families, especially those with young families. The social workers and the radiation oncology staff do their very best to try and reduce this stress and how this issue would be best resolved is unclear.

A significant issue we are faced with locally is with patients requiring hookwire placement. Unfortunately this service is not offered locally, so patients are required to travel over two hours to Canberra or Nowra. Having a hookwire placed is not pleasant at the best of times, add the additional pressure of a long journey pre and post placement and then having to sleep the night with the wire in place is far from ideal. This issue and issues like this are no doubt repeated across New South Wales. The remedy of these issues would help reduce the load on tertiary centres, surgeons and ancillary service and most importantly will make the journey down the cancer road a little less stressful and traumatic for these patients.

Regional areas as previously stated offer an effective and premium treatment option, even with is few faults. Working with breast cancer patients and survivors is one of the most rewarding parts of my position and participation in the ACT and SE NSW Breast Cancer Treatment Project helps increase survival rates and treatment option and I thank and congratulate all the professionals who work so tirelessly for positive outcomes in the treatment of breast cancer.

Danielle Hurley
Practice Manager for Dr Jonathan Rice, Surgeon
The General Practitioner - it’s all in the detail

The general practitioner plays an important communicative role in breast cancer management.

The general practitioner provides ongoing support and counselling to breast cancer patients and their families, as they adjust to the diagnosis of breast cancer and deal with the results of ongoing treatments and assessments. The general practitioner’s office is often the repository for ongoing diagnostic and assessment results, and offers an important opportunity for discussion and clear communication of results and further treatment options.

The patient and the GP may have evolved a trusting relationship over years. In many cases the general practitioner, having made an initial referral, remains the main communication face for the breast cancer patient. The general practitioner can also address many of the psycho-social issues and refer to other health specialists and counsellors as required. It is common for the general practitioner to take an active role in the ongoing follow-up of breast cancer. Once a patient has completed adjuvant treatments and appears to be disease free, routine follow-ups are usually with the general practitioner.

A Rural Perspective

My involvement with breast cancer patients is multifaceted; as a GP receptionist providing information to the BCTGQA Project on behalf of a rural GP; as a relative of family lost to the disease; as a survivor myself and as the organiser and facilitator of the local cancer support group network.

The Snowy Mountains, part of the SE NSW region, is a far-reaching rural area populated with close-knit communities. The closest hospital is in Cooma 63km from Jindabyne.

One of the main challenges encountered by a breast cancer diagnosis is the travelling involved in obtaining treatment. The initial diagnosis is, naturally, a shock to the system and the first reaction is to do whatever it takes. However, the realisation of location restrictions can prompt different results depending on the treatment plan.

As a GP receptionist, I am often asked if there are any local options. The usual response, reiterating referrals discussed by the GP is for surgery at either Bega or Canberra. For chemo and radiation therapy the options are initially Canberra or beyond. Often patients, if available to them, take a practical view and elect to spend their treatment period with family that takes them completely away from the area, frequently interstate. In this respect aspects of team planning and other elemental flexibilities are paramount to the patients’ wellbeing whilst being treated.

This is also a key topic of conversation amongst members of the local Jindabyne Network for Cancer Support. This is not a conventional support group because of the isolating nature of the local geography.

We do have a meeting place for group discussions and activities in Jindabyne but the main aim of the network is to provide a peer, reachable via telephone or email and if appropriate, able to visit on a one-to-one basis. The group has peer supporters in a range of different cancers but the greatest percentage is for breast cancer (approx. 84%).

For us, outside of the medical and oncology professions, knowledge sharing is a powerful tool. We are accepting that for each person there is an individual treatment plan with a variety of outcomes. The group has been running for two years now and during that short period recognises the changes in treatments and the benefits of those changes.

When the initial treatment is complete there are still follow-up and aftercare processes. This has improved considerably for rural patients by the welcome addition of Skype. As individuals take steps to return to a regular lifestyle there are still challenges ahead and the support is ongoing, along with the ability to share what they have learned.

In acknowledging that a diagnosis brings a new passage of life, we also know that ongoing research and review is essential to improvements in better treatment options and greater survivorship numbers. Knowing that the professionals are continually raising standards and creating new benchmarks through research and data collection is as important as the individual will to survive. We are all working in the same team!

Helen Blackmore-Lee
Receptionist,
Nuggets Crossing Family Practice.
Jindabyne

Thank You to all BCTG participating General Practitioners

We would like to thank all the General Practitioners who continue to contribute to the Breast Cancer Treatment Group Quality Assurance Project. Follow Up forms provide the important information about each participant’s continuing treatment and quality of life.

We would love to hear your story! If you would like to contribute to this valuable and widely read Newsletter.....we need you! Please send us any ideas or contributions or even an indication to contribute. You’ll find our contact details on the back page of this Newsletter.

from the BCTG Quality Assurance Project Team
Microcalcifications detected as an abnormality on screening mammography

BreastScreen ACT, in collaboration with the Calvary Hospital GP Liaison Unit, has developed an education module “Detection and Management of Early Breast Cancer” for General Practitioners in the Canberra region. This activity is accredited with the RACGP as an Active Learning Module Category 1 for continuing medical education. The GP has the opportunity to attend our assessment and result clinics to gain a deeper understanding of the techniques used for the diagnosis of breast cancer in women attending the program and the impact it has on the individual woman. This popular educational activity, now in its 6th year, receives excellent evaluations from all those who participate. It is planned that it will be offered again in 2014. Our sincere thanks go to the Breast Screen staff, the Calvary Hospital GP Liaison Unit staff and our patients for their willingness to share their knowledge and their journey with the GPs so that more women may benefit in the future.

The Breast Screen ACT program continues to have an active involvement with the ANU Medical School and ANU Academic Unit of General Practice through our contribution to the teaching program and offering research projects for medical students. Two of these projects have now been published with the latest publication in August 2013 based on work undertaken by Melissa Craft in 2008-9. Melissa is now a radiology registrar at The Canberra Hospital and gave a well received oral presentation of our paper at the Breast Imaging Meeting of the Royal Australian and New Zealand College of Radiologists conference in Darwin in June this year.

A summary of the paper: “Microcalcifications Detected as an Abnormality on Screening Mammography: Outcomes and Follow-up over a Five-Year Period”


The study retrospectively reviewed the outcome of 235 women recalled to an Australian breast screening program for assessment of microcalcifications in the year 2003 and examined the incidence of a breast carcinoma detected during the following 5 years in any of the women who were given a benign diagnosis at assessment. The medical records for the following five years were available for 168 women in the benign outcome group including those who did not require biopsy at initial assessment.

Malignant disease was detected in 26.0% (n=146) of the women who underwent biopsy. None of the women in the benign outcome group, with available five year follow-up records, developed a breast cancer arising from the calcifications initially recalled in 2003. The study highlights the effectiveness of an Australian screening program in diagnosing malignancy in women with screen detected microcalcification. This has been achieved by correctly determining 38% (n=235) of the women as benign without the need for biopsy or early recall. A low rate of open surgical biopsies was performed with no cancer diagnoses missed at the time of initial assessment.

Dr Anne Bicknell,
Clinical Coordinator.
BreastScreen ACT

NATIONAL LIBRARY OF AUSTRALIA

This year the Breast Cancer Treatment Group publications have had the honour of being included in the National Library Collection Series.
Changes in Breast Imaging at BreastScreen ACT

BreastScreen ACT underwent a major change in 2010. Up until that time mammography had been performed on an analogue system with the images recorded on film. In May 2010 the old analogue equipment was replaced with three Sectra Full Field Digital mammography units and a picture archiving and communication system (PACS) taking our imaging capabilities into the 21st century.

Since Roentgen’s discovery of x-rays in 1895 there has been a continual development of medical imaging.

Mammography had its beginnings in 1913 when Albert Salomon, a surgeon in Berlin, x-rayed 3,000 mastectomy specimens. Because of the high tissue dosage and poor image quality mammography was not a viable imaging application at that time. It was not until the 1950s and 60s with the development of dedicated equipment, film and standard positioning did mammography become more widely used. Between the 1970s manufacturers were producing dedicated mammographic equipment and film screen combinations which reduced the radiation dose and improved the image quality allowing mammography to become a reliable imaging tool.

The following two decades produced general improvements in mammography and also the development of other types of breast imaging. Ultrasound and magnetic resonance imaging (MRI) have both proven to be excellent breast imaging tools. Computed tomography (CT) gives too high a radiation dose and the poor spatial resolution makes it unsuitable for routine imaging. Thermography and xerography were not proven to be useful.

Digital mammography was developed in the late 1990s and was in use by 2000. The first large scale trial was done in the USA from 2001-2003. This was the Digital Mammographic Imaging Screening Trial (DMIST) which recruited 49,500 asymptomatic women to compare the results of film screen and digital mammography in this cohort.

The aim of the breast screening program is to reduce the mortality from breast cancer by 25-30%. This assumes bi-annual mammographic screening of 70% of the target population. In Australia this is women aged 50-74 years. The imaging systems used must give excellent diagnostic accuracy with minimal radiation dose.

A digital mammography system has advantages over an analogue system. It gives a lower radiation dose for the same standard two views of each breast. The images can be viewed immediately by the radiographer enabling any repeat images to be taken as required. The final images are viewed and reported in “soft copy” by the radiologist on high definition 5 megapixel screens. This allows manipulation of the images not possible with an analogue system. It is hoped that this will reduce the number of unnecessary call-backs for assessment. It has also been shown to increase diagnostic accuracy in certain subgroups.

Studies over the past decade have been done to assess differences in accuracy between film screen and digital mammography. No definite difference has been shown in post menopausal women with low density breast tissue over the age of 50. There is an improvement in sensitivity, however, in women under the age of 50 and in women of any age with dense breast tissue using the digital system.

Dense breast tissue is a difficult issue in breast imaging as mammographic sensitivity can be as low as 50 % in the screening population and lower still in younger women. Any improvement in sensitivity is beneficial in these groups.

The addition of an ultrasound examination may find cancers not shown on a dense mammogram. This is can be done routinely in a diagnostic clinic but not in a screening setting. If there is no abnormality identified in a dense breast on a screening mammogram there will be no recall to assessment and no further imaging will be done. This is why it is of the utmost importance that a woman with a clinical breast symptom should not come through the screening program but should be assessed at a diagnostic clinic.

Magnetic resonance imaging has a much higher sensitivity and specificity than mammography in dense breasts but the cost and lack of availability means it cannot be used for screening the general target population. It is currently used as the screening method of choice in high risk women under the age of 50 or as a problem solving tool in selected patients.

Tomosynthesis or 3D breast imaging is currently being evaluated as an adjunct to screening mammography. Results of studies to assess sensitivity and specificity and parameters including radiation dose, increased time of image acquisition and reporting together with the added cost of new equipment will determine if this is a viable screening solution for the future.

Breast cancer is the most common cancer in women in Australia but survival has improved over the past three decades. As in the past, imaging systems will continue to be developed, improved and become more widely available. This together with advances in treatment should continue the improvement in survival from breast cancer.

Dr Susan Bell, Radiologist.
BreastScreen ACT
Key presentations from the 2013 BCTG meetings

18th March 2013
Dr Angela Rezo led discussion around Strategic Planning for the Breast Cancer Treatment Group Quality Assurance Project. The focus of the presentation and subsequent discussion were:

• Defining a strategy process
• Re-visiting the initial objectives of the BCTG
• Summarising our achievements so far
• Strengths Weaknesses Opportunities and Threats analysis

Ideas for the future – e.g. a short period of more comprehensive data collection including Tissue Banking and Quality of Life information.

29th July, 2013 – Summary of presentation by Dr Saifulla Syed and Dr Usama Majeed
Breast Oncoplastic Surgery
Breast surgery has witnessed a paradigm shift in the management of breast cancer patients, from traditional mastectomy to breast conserving surgery (BCS). BCS involves wide local excision of the malignant tumour with tumour free margins, while at the same time preserving the rest of the breast (1). It has been shown to have a survival outcome equivalent to that of mastectomy (2). Other advantages of this procedure include breast preservation with a better view of body image, emotional well being, less adverse sequelae from asymmetry, chest wall adhesions, and numbness associated with mastectomy (3, 4). However, breast conserving surgery has its limitations including deformity, poor cosmesis and the need to re-excise margins if they are positive (5).

Breast oncoplastic surgery is a relatively new technique that has revolutionised the management of breast cancer. Considered as the third pathway between standard breast conserving surgery and mastectomy, it involves excision of the cancer followed by immediate reshaping of the breast so as to maintain its shape and contour (6). It combines oncologic and reconstructive approaches with the aim to achieve complete tumour excision with the best possible aesthetic outcome (6). A number of studies have shown the safety and efficacy of breast oncoplastic surgery (7, 8). Further, it has been shown to overcome the limitations of breast conserving surgery.

As a part of multidisciplinary approach, our local surgical team offers all surgical services including breast oncoplastic surgery and reconstructive procedures for the management of women with breast cancer.

Dr Saifulla Syed. Breast Surgery Fellow. Calvary Healthcare ACT

N.B. for a complete list of references (see above) please contact the Project Officer, BCTG

4th November, 2013 – Summary of presentation by Professor Afaf Girgis
Challenges and support for cancer survivors and their carers
Prof. Girgis examined the various challenges and support mechanisms currently in place for cancer survivors and their carers. Her recent Cancer Survival Study, Australia’s largest population-based longitudinal study of prevalence and predictors of adult cancer survivors’ psychosocial wellbeing and lifestyle behaviours included 1,453 consecutive cases diagnosed with top 8 incident cancers recruited from cancer registries in 2 large states.

It was a self-administered scannable survey. Two years after diagnosis 1 in 5 survivors still perceive cancer as a stressful life event.

Cancer caregivers are at risk of high levels of anxiety and depression, poor quality of life, social isolation, financial burden and physical health risks. The impact of cancer from diagnosis, through appraising the event and individual coping style and the patient’s biological response have influence on physical health, emotional well being, social functioning and spiritual/ existential well being.

Prof. Girgis spoke about two current studies in which she is involved. The first is PROMPT, Personalised Medicine through System-wide change through Clinical Care, Self Management and Personalised Therapy.

The second study is “Coping Together” a three-group, parallel, randomised controlled trial. Various booklets, DVDs and CDs as well as a website have been produced for cancer survivors and their care givers. Reported Benefits of Coping-Together are:
• Facilitating independent coping • Connecting patients and partners to people and services • Complementing support received from health care professionals • Gives hope that something can be done to “pull through”

Prof. Afaf Girgis. Executive Director, Translational Cancer Research Unit, Ingham Institute for Applied Medical Research, UNSW. Sydney.
BCTG Journal Publications:


ABSTRACT

AIM:
There is debate as to what constitutes an adequate excision margin to reduce the risk of locoregional recurrence (LRR) after breast cancer surgery. We have investigated the relationship between surgical margin distance and LRR in women with invasive breast cancer (IBC).

METHODS:
Tumour free margin distances were extracted from histopathology reports for women with IBC, treated by either breast conserving surgery or mastectomy, enrolled in the Breast Cancer Treatment Group Quality Assurance Project from July 1997 to June 2007. Cox proportional hazards regression analyses were conducted to compare the risk of LRR for involved margins compared with negative margins, measured in increments rounded to the nearest mm.

RESULTS:
88 of 2300 patients (3.8%) experienced an LRR after a mean follow-up of 7.9 years. An involved margin, or a margin of 1 mm was associated with an increased risk of LRR (HR 2.72, 95% CI 1.30-5.69), whilst margin distances of 2 mm or greater were not. Risk of LRR with margin distances <2 mm was particularly high amongst those not receiving radiotherapy (RT).

CONCLUSION:
Based on our findings, we recommend that a tumour free margin distance of 2 mm be adopted as an adequate margin of excision for IBC, in the setting of patients receiving standard adjuvant RT and adjuvant drug therapies as dictated by the current clinical treatment paradigms.

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The Canberra Times 4 November 2013

Congratulations to Yanping Zhang who was recently featured in the Canberra Times (4th November, 2013) for her work on the BCTG Quality Assurance Project. Yanping is currently in her 16th year of working on the Project and is honoured to be a part of this important research.

An excerpt from the article: “Yanping Zhang is not a doctor but her contribution to breast cancer research in the ACT has potentially helped save lives and improved outcomes for the thousands of ACT women and handful of men who have been diagnosed with the disease over the past 15 years.

For 15 years, Ms Zhang has collected detailed medical data on almost every breast cancer case in the ACT. With the voluntary co-operation of 250 clinicians, more than 900 GPs and more than 5,000 cancer sufferers, her data set encapsulates details on 96% of breast cancer cases in the ACT and surrounding region unheard of in other population studies.”
Acknowledgements

Special thanks go to all the surgeons and general practitioners, breast care nurses, radiologists and oncologists for their time, patience and continuing hard work. The considerate and generous involvement of all contributors ensures the continuing success of the BCTG data collection.

Special thanks to the medical practice staff for their patience and continuing support and hard work.

Also thanks go to Bosom Buddies for ongoing support this year.

In addition we wish to thank ACT Pathology, Capital Pathology, and BreastScreen ACT for their support.

Thanks also to Astra Zeneca, Novartis and Amgen for sponsoring the Breast Cancer Treatment Group meetings and speakers this year, and also thanks go to Lyn North and staff at University House, ANU for providing the venue and resources for our meetings.

Gentle Yoga – pathway back to wellbeing

After specialist cancer treatment, patients often feel overwhelmed and depleted. Yoga therapy for cancer survivors is emerging as one of the more successful techniques for combating the physical and emotional discomfort of cancer and cancer treatment. Many find that yoga as therapy for cancer provides an ideal, balanced form of whole-body exercise. For those enduring chemotherapy and radiation, or recovering from surgery, yoga offers a means to strengthen the body, boost the immune system, and create a feeling of well-being. Yoga can help restore motion and flexibility in a gentle, balanced manner.

A 2011 study presented at the 47th annual meeting of the American Society of Clinical Oncology reports that “yoga improves quality of life and lowered stress” in breast cancer patients undergoing radiation treatment. In 2010 the University of Adelaide conducted research into the benefits of yoga for women who had lymphoedema following breast cancer surgery with the result that there was reported subjective life improvement and general mobility as well as reduction in stress levels.

Regular yoga practice improves the quality of life for everybody. Besides physical mobility, enhanced energy, strength and balance, other gains such as mental focus and increased self-awareness are major outcomes. There is no age barrier, and yoga can be adapted for people of different physical capacities, for its key practice is mindfulness.

With thanks to Pamela Bleakley, Yoga Instructor, for the idea for this article.

Collaborations with National Studies

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS (RACS)

The Breast Cancer Treatment Quality Assurance Project continues to provide high quality data for our surgeons via the National Breast Cancer Audit Report to the RACS.

All RACS data requirements are set up in the BCTG project database, making it a very simple exercise to directly submit requisite data for participating surgeons on a regular basis. The key benefit for our surgeons is convenience and an improved means of time management.

BREAST TISSUE BANK

BCTG Quality Assurance Project and the Breast Tissue Bank continues working together to ensure quality data.
2014 dates for BCTG meetings

BCTG meetings will be held in the Drawing Room, University House, ANU at 6pm on:

Monday 24th March, 2014
Monday 28th July, 2014
Monday 17th November, 2014

The BCTG newsletters, reports, publications and information of interest can be found at: http://www.health.act.gov.au/Research/breast-cancer-research
Farewells and Welcomes

There have been a few movements in the BCTG Project Team during 2013.

Congratulations to Thet Khin who welcomed a new baby boy into her life in November.

Jenny Green is the Project Officer while Thet is on maternity leave, and Mary-Claire Tryon has taken up a casual position to help clinicians on the data collection and pathology audit. This position is funded by the Canberra Hospital Radiation Oncology Private Practice Fund.

Contact Details

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

Project Co-ordinator/Data Manager
Yanping Zhang
Telephone: (02) 6205 0967
Email: yanping.zhang@act.gov.au

Mailing address
Breast Cancer Treatment Quality Assurance Project
ACT Health
GPO Box 825
ACT 2601

Website

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