The Breast Cancer Treatment Group and the quality activities it undertakes are now into their tenth year. The Group continued its major activities of collecting data on breast cancer treatment from participating clinicians, collaborating on scientific studies, and exchanging information on breast cancer treatment including several excellent continuing education sessions.

Excellence in breast cancer treatment is particularly important in the ACT because of the high rates of the disease in our community. These high rates are related to the high prevalence of risk factors we have here, including a relatively high socioeconomic status population, low numbers of births and older age at first birth. While our breast cancer incidence is higher than the national average in the ACT, our breast cancer mortality rate is the same as the national average. Good breast cancer treatment is an important contributor to this outcome.

The work of the BCTG has been presented to the National Cancer Institute in China and the American Society of Clinical Oncology. In the coming year we hope to do a summary analysis of our ten years of breast cancer treatment data, and a survival analysis of people diagnosed with breast cancer.

I would like to thank all the participants in the BCTG for their contributions this year, as well as all practice staff and administrative staff who have assisted in bringing our data sets up to date. I look forward to continuing to work with you all in 2008.

Dr Paul Dugdale
Chair of the ACT & SE NSW Breast Cancer Treatment Group

Thank you and farewell
This year we are saying a sad but fond farewell, and hearty congratulations to Professor Noel Tait. Noel will be taking up a Professorship of Surgery position with the University of Wollongong as of 1st February, 2008. The Breast Cancer Treatment Group and the Data Collection Sub-Committee will truly miss Noel’s continual support and commitment towards improving the treatment of breast cancer patients. He was instrumental in our establishment in 1997 and has ensured valuable information was continually flowing to the Project.
Dr Paul Craft

This year has seen the focus of the committee on maintaining the data collection and striving to complete a first analysis of outcomes of treatment across the now very large cohort of women (and some men). As can be seen from the graphs and chart in this newsletter some 2,883 persons treated for breast cancer within the region are included. The collation of outcomes information is a major challenge for the project as it involves contacting treating medical practitioners to determine if a recurrence or other problem has occurred in the interval since initial treatment. For some of our participants this initial treatment occurred more than 10 years ago. People move, doctors retire or leave their practices. Attempting to track down ‘lost’ participants has proven to be a greater challenge than we anticipated. Thus we are only now on the threshold of presenting the first reliable outcome results. That this has been achieved is a tribute to our hard working data managers, who have borne the main brunt of the work. We were delighted, early in the year, to receive fantastic financial support from Bosom Buddies which allowed the appointment of a part time staff member for data checking.

While the collection of outcome data has been a massive undertaking, I am sure the endeavour will add much to the value of the project. In addition to thanking our staff, I would like to thank the hardworking Data Management Subcommittee membership, which has met late in the evenings and expended much time on cleaning data and advising the project officers. I think we can look forward to significant progress in 2008, where the real value of our hard won treatment information will become clear.

Ten years of data collection

ACT & SE NSW BCTG Quality Assurance Project

The Breast Cancer Treatment Quality Assurance Project reached its 10th anniversary in June 2007. We have successfully collected over 3000 new breast cancer cases in the ACT and surrounding regions (Graph 1), with 96% of these patients giving their written consent to participate. Graphs 2–6 provide information for all patients (n=2883) with invasive and DCIS disease and their treatments. The last figure (Graph 7) shows preliminary results of 10 years’ follow-up data for female unilateral breast cancer patients (n=2408) who underwent initial surgery between 1 July 1997 and 30 June 2006.

Graph 1 Breast Cancer Cases in ACT and SE NSW, n=3005 (1 July 1997–30 June 2007)
**Graph 2** Characteristics of Patients and Tumour (n=2883*)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at diagnosis (median)</td>
<td>57.1 years</td>
<td>23-96</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>2864</td>
<td>99.3%</td>
</tr>
<tr>
<td>Male</td>
<td>19</td>
<td>0.7%</td>
</tr>
<tr>
<td>Menopausal status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-</td>
<td>746</td>
<td>25.7%</td>
</tr>
<tr>
<td>Post-</td>
<td>1853</td>
<td>61.0%</td>
</tr>
<tr>
<td>Peri-</td>
<td>255</td>
<td>8.9%</td>
</tr>
<tr>
<td>Unknown/Male</td>
<td>29</td>
<td>1.0%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invasive carcinoma</td>
<td>2542</td>
<td>88.5%</td>
</tr>
<tr>
<td>In situ disease only</td>
<td>329</td>
<td>11.5%</td>
</tr>
<tr>
<td>Tumour extent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distant metastases at diagnosis</td>
<td>52</td>
<td>1.8%</td>
</tr>
<tr>
<td>Synchronous bilateral tumours</td>
<td>193</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

* Participants have given written consent and have a completed data collection form.

**Graph 3** Breast Cancer Treatment in ACT and SE NSW, n=2843* (1 July 1997–30 June 2007)

- **Invasive Carcinoma (N=2516 (88.5%)**
  - Breast conserving: 1752 (69.5%)
  - Mastectomy: 764 (30.5%)
  - Adj. treatment: 81 (3.2%)
- **Ductal carcinoma in situ (N=327 (11.5%)**
  - Breast conserving: 230 (70.0%)
  - Mastectomy: 87 (26.5%)
  - Adj. treatment: 10 (3.1%)

**Graph 4** Method of Detection and Tumour Size

<table>
<thead>
<tr>
<th>Method of Detection</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>BreastScreen</td>
<td>1108 (94.5%)</td>
</tr>
<tr>
<td>Other Screen</td>
<td>456 (38.9%)</td>
</tr>
<tr>
<td>GP</td>
<td>7 (0.6%)</td>
</tr>
<tr>
<td>Patient Self</td>
<td>5 (0.4%)</td>
</tr>
<tr>
<td>Other</td>
<td>6 (0.5%)</td>
</tr>
</tbody>
</table>

**Graph 5** Axillary Surgery

- No Axillary Surgery: 300 (10.6%)
- Clearance only: 300 (10.6%)
- Sentinel node biopsy only: 300 (10.6%)
- Sentinel node + Axillary: 300 (10.6%)
- Mastectomy: 300 (10.6%)

**Graph 6** Post-operative Adjuvant Therapy

- Radiotherapy: 300 (10.6%)
- Chemotherapy: 300 (10.6%)
- Hormone therapy: 300 (10.6%)

**Graph 7** Breast Cancer Outcomes, n=2408* (1 July 1997–30 June 2006)

- Alive, disease free: 2200 (91.2%)
- Recurrence or death due to BC: 200 (8.0%)
- Died without evidence of BC: 100 (4.2%)
- Lost to follow-up: 0 (0.0%)
- Status unknown or missing: 0 (0.0%)

* Female, unilateral breast cancer patients only.
Thank you to all GPs.
Those very vital purple follow-up forms —
Your response does make a difference!

In 2007, 1523 follow-up forms were sent out to clinicians and GPs. For some patients it may be their first follow-up (1 year after initial treatment) or in this tenth year of the project, their 10th year of follow-up. The information collected from these forms is vital to the success of the Project, and in producing valuable statistics, which will lead to improved treatment for patients with breast cancer.

Of the 1523 forms sent out, the Quality Assurance project office has received 1101 responses from General Practitioners so far. It is never too late to send in a form since information can be backdated.

If you have any purple forms lying around, even if you have no information on the patient, please let us know by returning the form to the “Cancer Treatment Quality Assurance Project, ACT Health, 1 Moore Street, Reply Paid 825, CANBERRA ACT 2601.”

The general pattern is that the clinician may see the patient for between 1 to 5 years. Any time after one year the GP may be the only contact with the patient. The project does not contact patients directly but depends on the goodwill in time and effort from the GPs for feedback. So a huge thank you to all the GPs who contributed toward the pursuit of improved treatment for their patients.

Thankyou to Paul Dugdale as our Chair, and Carolyn Cho, our Deputy Chair, for organising the interesting speakers and sponsors — Astra Zeneca, Roche and Pfizer for sponsoring the Breast Cancer Treatment Group meetings.
Elspeth writes...

Congratulations to BCTG from Breast Cancer Network Australia. As a consumer representative from BCNA, I have found it valuable to be a member of the BCTG, to have a seat at your table. Our expertise is in the experience of Australian women who have been affected by breast cancer, and the issues that are important to them. As advocates, we are able to raise these issues with your group in relation to your research and we are also able to take issues back to BCNA. Through our relationship with the clinicians and health care professionals in BCTG, your expertise is available to our women – an excellent example was Jane Dahlstrom’s address to 300 women at a BCNA Forum in the ACT. We look forward to another productive year of research and discussion.

Thank you to Elspeth Humphries, our very valued Consumer Representative for her participation in BCTG meetings, and interest in our activities throughout 2007.

Events of the Year Presentations

In May this year, Jeremy Price, Radiologist in the ACT presented his experience on “Breast Cancer Evaluation with MRI”.

In August, Julie Johns, Research Data Co-ordinator from Royal Melbourne Hospital, presented “The Molecular Medicine Informatics Model”.

Our last speaker of the year was Professor Neil Pillar from Flinders University speaking on “Lymphoedema”.

Helen Porritt, Nurse Counsellor, ACT Breastscreen comments on November’s educative presentation by the Director of the Lymphoedema Assessment Clinic, Flinders University.

“At the November meeting we were fortunate to have a presentation by Professor Neil Pillar Director of the Lymphoedema Assessment Clinic at Flinders Surgical Oncology in the Department of Surgery in the School of Medicine at Flinders University and Medical Centre, South Australia. The presentation challenged us to think about Lymphoedema and the lymphatic system in relation to breast cancer treatment. Neil discussed the realities of the lymphatic system and how the function may be disrupted by surgery and radiotherapy, and the mechanisms used by the body to compensate. He emphasised how important it is to identify a patient at risk and consider the balance between the three clinical phases of Lymphoedema — fluid, fatty/fluid and fibrous/fluid, determine evidence of subclinical Lymphoedema and initiate early active treatment and management.

Neil related his successful research proving Low Level Laser Lymphoedema therapy or Cold Laser Lymphoedema therapy as a form of assistance in Lymphoedema regulation and control. This therapy is used both nationally and internationally. He is presently involved with other researchers on the development of a pain assessment scale for dementia suffers. Neil has had a busy year travelling nationally and internationally relating his knowledge and research results in the treatment and diagnosis of Lymphoedema.”

Professor Pillar can be contacted on email Neil.Pillar@flinders.edu.au.
In recent years, contrast-enhanced breast MRI has established a key role in screening high-risk women. In this group, cancer detection rates with MRI are around double those achieved with conventional x-ray mammography. MRI works by showing the neo-vascularity associated with malignancy and, unlike x-ray mammography, performance is not affected by breast density.

The sensitivity of MRI for invasive cancer is around 95%. MRI also has high sensitivity for DCIS, particularly the clinically-important high nuclear grade disease. However, MRI does not directly show micro-calcification, and fears that low-grade DCIS could be missed mean that MRI is not recommended as a replacement for x-ray mammography.

With known cancer, the ability of MRI to accurately depict the overall extent of disease has the potential to influence treatment. MRI is particularly used in staging of invasive lobular cancer, to detect occult multifocal or contralateral disease.

MRI can also be used where residual disease is suspected after surgery. Initial concerns that MRI could be misleading in the early post-surgical period have proved unfounded. In reality, the main limitation on post-surgical MRI is how soon the patient can lie comfortably on their front!

A further potential role for MRI is in monitoring response to chemotherapy. Research has shown promising results using quantitative analysis to detect non-responders, avoiding the need for multiple cycles of ineffective therapy.

While the sensitivity of MRI is excellent, false positives remain problematic, as some benign lesions can show worrying patterns of enhancement. Careful follow-up is required as a minimum, while in some cases MRI-guided biopsy or hook-wire localisation are used to obtain histology.

Dr Jeremy Price, Radiologist

Ten years of achievement

The Breast Cancer Treatment Group was initiated in 1997. Since that time regular articles have been written and accepted by notable publications, and many audiences have benefited from the pertinent presentations at conferences and in-house, both drawing on the quality data contained within the database, and from information provided by the quality presenters at the Breast Cancer Treatment Group Meetings.

Articles and papers published and presented by members of the Australian Capital Territory and South Eastern New South Wales Breast Cancer Treatment Group can be found at:


2008 Presentations

Come along to the 17th March 2008 meeting and hear Dr Nicole Gorddard, Staff Specialist in Medical Oncology at The Canberra Hospital present an Update on chemotherapy for Early Breast Cancer – areas of consensus and controversy.

On 19th May, Dr Helen Zorbas, Director of the National Breast and Ovarian Cancer Centre will be our guest speaker. Dr Zorbas is directing a number of key national projects and programs in evidence-based practice, clinical service improvement and psychosocial support to improve cancer care. She is also a practicing breast physician, and has a staff specialist appointment at the Rachel Foster Breast Clinic, Royal Prince Alfred Hospital, Sydney.
For eighteen months now Sue Pittman, Oncology Social Worker has been providing oncology psychosocial services to a small part of the Greater Southern Area Health Service, including Queanbeyan, Yass, Braidwood, Cooma–Jindabyne area, and Goulburn.

Each location requires different services depending on the resources in their area. It may be that Yass has a higher need for her services for a period of time, then Cooma’s needs rise, and then Queanbeyan has an increasing number of people needing her attention.

The Cancer Institute NSW Oncology social work service position is funded for 3 days a week. This incorporates travel around the countryside to meet people personally, as well as liaising by phone, and running psycho-social clinics in those areas where there are a number of people, and their families to follow up.

Sue has noticed that people often wait until there is a crisis before they feel the need for her input. She has been impressed that many patients and their families do have extraordinary coping skills. It is well recognised that the support of family, friends and networks is significant in managing life threatening, chronic illness.

The Oncology Social Worker will work closely with the other services in each area, especially Community Health, and is in the unique position of working independently from a single medical cancer service. This has lots of challenges and also real advantages, as the focus can be on patient’s non-medical needs without being sandwiched among appointments and tests.

Patients, families and health referrers can contact the NSW Oncology Social Worker through reception on 6298 9233 and leave a message. Calls can then be returned during workdays Mon to Wed.

Sue Pittman
Oncology Social Worker and
SE NSW representative, Greater Southern Area Health Service

New Deputy Chair

Dr Carolyn Cho will take over the position of Chair of the Breast Cancer Treatment Group in 2008. Professor Jane Dahlstrom has kindly offered to support Dr Carolyn Cho as the Deputy Chair. We look forward to a great year!

Dr Wayne Wardman
Ginninderra Medical Practice,
Belconnen, ACT

From my student days to the present I have seen breast cancer evolve from a virtual ‘death sentence’ to a disease that is survivable. Furthermore, the 5 year survival rate I was taught has paled into irrelevance as post-diagnosis life spans have progressively increased.

Whilst the true cure still evades our abilities, it is within conceptual sight.

This enormous change, in but 30 years, has not occurred by accident. Large amounts of work form the basis of such successful scientific endeavour.

The fact that the progress of breast cancer sufferers is being monitored around the globe by such groups as Breast Cancer Quality Assurance Group adds to the momentum of the on-going nature of our advances.

As a General Practitioner, I am pleased to be a part of this process. Whilst the incidence of the disease remains high, each follow up form I fill out reminds me of the huge advances made to date and that the nature of disease is being understood more completely each day.

Dr Wayne Wardman
General Practitioner
Acknowledgements

Special thanks to the hard-working medical receptionists for their continued support in liaising with the Project Office. This year we were also fortunate to have some financial support from Bosom Buddies that enabled medical student Anita Hutchison to provide assistance for the Project. Thank you Bosom Buddies and Anita!

2007 has been a significant year in the data collection process, and so a huge THANK YOU is sent to all the GPs for their timely processing, and most valued support in completing the follow-up forms. This is what enables the project to obtain the valuable information, which will lead to better health outcomes for patients with breast cancer. Your contribution is greatly appreciated!

In Memory of Dr Doris Zonta (Brownlee)

Undoubtedly many of you would have been saddened to hear that Dr Doris Brownlee passed away on 8 December 2007. Doris was the ACT Chief Health Officer between 1995 and August 1998, and the first chair of the ACT & SE NSW Breast Cancer Treatment Group (BCTG). At the time she was known as Doris Zonta.

Following the publication of the NHMRC Clinical Practice guidelines for the management of early breast cancer in 1996, and the establishment of the BCTG, Doris was approached to chair the committee — a task she took on with enthusiasm. Doris was very supportive in developing the terms of reference, local protocols for incorporating different treatment modalities with the region, and other issues related to the National Guidelines. One of the activities undertaken by the group was the Quality Assurance Project. Doris was instrumental in establishing the project as a long term funded activity by ACT Health. She was an effective and well-respected Chair of the committee from 1996 to 1998.

Those who worked with her fondly remember Doris. The Breast Cancer Treatment Group send our condolences to Doris’s family.

CONTACT DETAILS

If you have any enquiries or comments about the project, please contact the Project Office. Any clinical queries should be directed to Dr Paul Craft at the Canberra Hospital on (02) 6244 2220.

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