

NEWSLETTER

ISSUE 6

DECEMBER 2006

The Breast Cancer Treatment Group



Dr Anne Bicknell

It has been a successful year for the Breast Cancer Treatment Group, now fast approaching its 10th anniversary. Support for the project is strong with 37 clinicians

involved and 2800 patients recruited – on average 300 per year. This is an extraordinary result given the voluntary nature of the project and is a great tribute to all those involved. The high participation rate represents a wealth of patient data and outcomes, which can now be followed with interest over the next decade. The first 10 years has seen the publication of the 5 year report – an outstanding achievement of the project. It is now time to re-evaluate where we are at present, where we would like to take the group into the future and how best to manage this. An ideal opportunity for this to happen would be to make it the focus for discussion at the first group meeting for 2007.

The membership of the Breast Cancer Treatment Group was broadened this year to include local representatives from the disciplines of Genetic Counselling, Cancer Psychosocial Services and Radiologists with a special interest in breast imaging. With eight new members welcomed to the group our meetings have become a forum for lively discussion over issues important to the group and an opportunity for continued networking with individuals within our community who have an interest in Breast cancer treatment.

Educational presentations from within our own membership and externally invited speakers have provided interesting and varied topics for discussion.

Dr John Buckingham spoke to us in February of the highlights from the San Antonio Breast Conference, Texas, which he attended in 2005. Another important, and often neglected area, of Breast Cancer treatment was addressed by Dr Kendra Sundquist in her presentation “Sexuality and Breast Cancer”. Practical ways for clinicians to initiate discussion of sexuality issues with their patients was covered and useful resources available to aid clinicians in supporting their patients noted. Our speaker for the August meeting was Dr Lyn Austin who described the latest advances in partial breast irradiation to us. We welcome Dr Judy Kirk to our November meeting for a presentation on “Genetic Aspects of Breast Cancer”. We gratefully acknowledge the support for these meetings given by our sponsors.

As 2006 draws to a close I would particularly like to thank our Project Coordinator/ Data Manager, Yanping Zhang and Project Officer, Robyn Bradley, for the work they contribute towards this unique venture – it is through their tireless efforts that we are able to continue to consolidate our past achievements and move the Breast Cancer Treatment Group forward into the future.

It has been a privilege for me to be in the position of Deputy Chair of the Group this year. Thank you all for your support and in particular the leadership from the Chair, Dr Paul Dugdale.

Dr Anne Bicknell
Deputy Chair
ACT and SE NSW Breast Cancer
Treatment Group
14th November 2006

THANK YOU

A special thank you to Anne Bicknell for her valuable voluntary contribution to the Breast Cancer Treatment Group for 2006. She has provided an important role as Deputy Chair in supporting the ongoing activities of the Group.

GREAT SUPPORT FROM BOSOM BUDDIES

We would like to take this opportunity to say ‘thank you’ to Bosom Buddies and Pam Robertson for their generous contribution to the Project. We appreciate and are very grateful to all involved.

2007 dates for your diary

Breast Cancer Treatment Group Meetings

Monday 6.00pm
Drawing Room, University House, ANU
5 March, 21 May, 27 August,
19 November

Breast Cancer Treatment Group Data Collection Subcommittee Meetings

Tuesday 6.00pm,
Training Room 1, ACT Health Building,
Level 1, 1 Moore St Civic
27 February, 12 June, 16 October

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ACHIEVEMENTS AND PRESENTATIONS FOR THE YEAR

Research held by Drs Karl Rodins, Angela Rezo, Alison Davis and Jane Dahlstrom won the Board of Education



Dr Jane Dahlstrom

poster prize at the Royal College

of Pathologists of Australasia (RCPA) update meeting in Sydney in March this year. The title of the project was "A retrospective analysis of tumour size and lymph node status in multifocal breast cancer in Australian Capital Territory and South Eastern New South Wales"

Breast Cancer Network Australia (BCNA) held a very successful forum for the ACT and Greater Southern Region on August 21 at the National Library theatre. The purpose of the forum was to give women in the area an update from BCNA. The local organisers included Elspeth Humphries, a member of the ACT and SE NSW Breast Cancer Treatment Group. The speakers included Ms Raelene Boyle, with the local speaker being Dr Jane Dahlstrom. Jane spoke on pathology, teaching and our quality assurance project.

The position of Project Officer to the BCTG Quality Assurance Project, which had been covered by temporary staff since May 2005, was re-instated in a permanent position when Robyn Bradley commenced on 31 July.

GUEST SPEAKERS

February: Dr John Buckingham
"Highlights of the San Antonio Breast Conference USA 2005"

May: Dr Kendra Sundquist
"Sexuality and Breast Cancer"

August: Dr Lyn Austen Radiation Oncologist, The Canberra Hospital,
"Partial Breast Irradiation"

November: Assoc Prof Judy Kirk (Westmead Institute for Cancer Research, Westmead Hospital)
"Genetic aspects of Breast Cancer"

Report from the Chair of the Data Management Sub-Committee

In 2006 the Subcommittee continued to meet on a quarterly basis. As Chairman I thank the members for contributing so much of their own time to the endeavour. Most importantly, data collection has continued throughout this year, with enrolment in line with our expectations. We now have over nine years of data available with treatment details of over 2800 women. This effort has now put the Group in a position to start to look at outcomes of treatment. The task over the next few months for our hard working staff will be, in addition to maintaining the ongoing collection, to also clean, check and enter all of the outstanding follow-up forms. This information will be crucial to examining results of treatment and will help identify areas where care of patients with breast cancer can be improved or refined.

Since the last newsletter we have been very fortunate to appoint Ms Robyn Bradley as our project officer to work with Yanping Zhang. Robyn has contributed greatly to the conduct of the project. Yanping remains as enthusiastic as ever guiding the data collection.

Good use has been made of the dataset since the five-year report was published.

In particular, members of the group received a prize for best poster presentation at the recent College of Pathologists conference for their study "Retrospective analysis of tumour size and lymph node status in multifocal breast cancer patients".



Dr Paul Craft

The Subcommittee remains concerned to keep the project active and viable. The long-term nature of the data collection is becoming a major strength, showing, for example, the rate of diffusion of new innovative treatments into standard practice. Maintaining the program over such a long time does place a strain on all participants particularly our reporting clinicians. Over the next year, as we look at long term treatment outcome results, a further challenge will be to review the conduct of the project and consider changes that will allow it to continue to succeed during the second five years of patient accrual.

Dr Paul Craft, Chair of the Data Management Sub-Committee

A GP's perspective on the Breast Cancer Treatment Quality Assurance Project

After I have taken a PAP smear and a BP I ask ... "and do you have regular mammograms?" Years back I had to spend time 'selling' the idea of breast screening mammography. Now only very occasionally do I need to explain the possible advantage of breast screening in identifying cancer early.

For those who already have breast cancer, it is important for them to know that their treatment options are best practice for their type of cancer. The Quality Assurance Project has been working away for the past nine years, collecting data from volunteers who have already undergone a variety of treatments. As a GP I play my part by keeping the Project informed of the treatments being undertaken, and how the patient is

progressing, especially when the surgeon is no longer in contact with them. Each piece of information helps with the bigger picture and over time best practice will be confirmed.

At the end of most days I face a pile of paper work and email results, but on seeing the BCTG's purple follow-up forms, I enjoy responding to the questions:

Is the patient still alive?

Is the patient disease free?

I know that this bit of paper has the power to effect other breast cancer patient's lives in a positive way. With early diagnosis and quality treatment, most times I can scrawl YES on the questionnaire.

Dr Jacqui Lowe
General Practitioner

MULTIFOCAL BREAST CANCER: What's the question again??

Dr Angela Rezo, Radiation Oncologist

Multifocal breast cancer was a popular topic in the 1980's when the standard operation for breast cancer was changing from mastectomy to breast conservation surgery. Numerous authors at the time warned of the dangers of breast conservation given that the incidence of other deposits of disease within the rest of the breast approached 70% in some series¹. The incidence of multifocal disease depends largely on the way in which the mastectomy specimen is sampled. Breast surgeons have largely accepted that these microscopic foci are left behind in the distal breast tissue and that this disease is dealt with adequately using breast radiotherapy.

Today the common question asked about multifocal disease is in relation to adjuvant therapy. Repeatedly in multi-disciplinary clinics a medical oncologist asks whether the risk of recurrence is estimated based on the size of the largest focus or an aggregate measurement. Radiation oncologists ask the same question about women who have had a mastectomy. Essentially we are uncertain if the biology of this disease can be predicted by the biology of the largest tumour (the underlying assumption of the current staging system) or whether the aggressiveness of the multifocal disease is equivalent to that of a single tumour with a diameter that is the aggregate diameter of all the foci. Is the biology really *that* bad?

Studies that have addressed this question to date have been consistent in their findings that multifocal disease is associated with a higher frequency of nodal metastases^{1,2,3,4,5}. Is this higher tendency to metastasise to nodes occurring simply because we are not correcting for tumour size appropriately or is multifocal disease biologically more aggressive? Andea² et al found that if an aggregate diameter for multifocal cancer is used, the frequency of lymph node metastases is the same when comparing unifocal to multifocal disease. Coombs³ et al confirmed these results.

In a later publication Andea¹ et al went further and found that when aggregate tumour volume is measured, cell for cell, multifocal disease has a higher propensity to spread to lymph nodes than unifocal disease of the same volume. This suggests

it is the cellular behaviour of multi-focal disease rather than under-estimation of clonogens that explains the phenomena.

Fish⁴ et al used a step-wise Cox regression to assess if tumour size (measured in four ways - using laborious three-dimensional tumour measurements) was a significant factor in relation to time to death in multi-focal breast cancer. They found that tumour size is only a significant variable if tumour surface area or volume of all the nodules are used, and that tumour size is not a significant explanatory variable if diameter of the largest focus or an aggregate diameter is used.

To summarise, the Andea and Coombs studies would suggest that an aggregate diameter of all the foci should be used in estimating the risk of nodal metastases. The Fish study would suggest that an aggregate surface area or volume measurement of all the foci predict time to death. So which measurement of tumour size should be used in recommendations for adjuvant treatment? Is the risk of nodal metastases important in making decisions regarding axillary surgery? A recent prospective study by Knauer⁵ et al shows that multifocal and unifocal breast cancer have the same false negative rate using sentinel node biopsy.

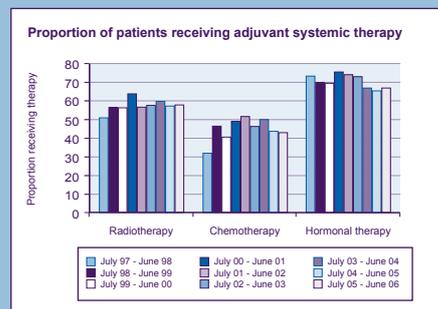
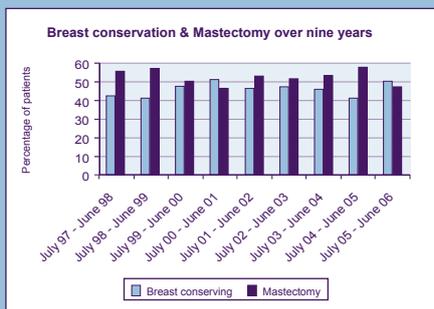
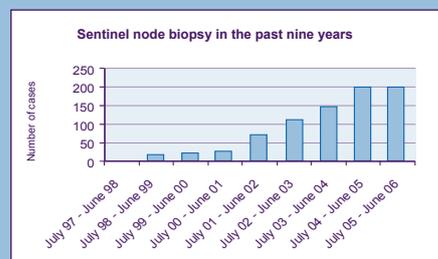
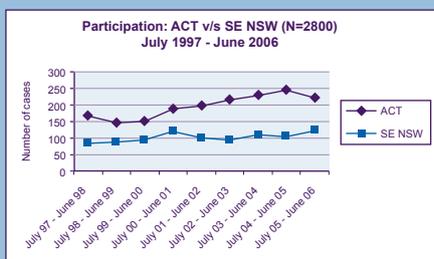
In recommending adjuvant systemic therapy the outcomes of interest are relapse-free and overall survival, so

perhaps an aggregate surface area or volume measurement using three-dimensional measurements should be undertaken. Loco-regional control as an endpoint is not addressed in these studies of multifocal breast cancer so there are no clear guidelines as to how multifocality is incorporated into risk estimates.

Given the uncertainty that stills exists, a project was approved by the ACT Human Research Ethics Committee using the ACT and South-East NSW Breast Cancer Treatment Group Quality Assurance Project database. Over a hundred women with multifocal disease have been identified and these are being compared with over a thousand women with unifocal disease who were registered during the same period. An early presentation of the data using a limited number of women in the control arm has been presented at the Annual Scientific Meeting of The Royal College of Pathologists of Australasia (RCPA) by Dr Karl Rodins for which he was awarded the poster prize! The results showed that there is no statistical difference between the rates of nodal metastases when the aggregate diameter of multi-focal disease was compared to unifocal breast cancer of the same size. Data from the entire cohort of women with unifocal disease is being collated to see if this earlier result looking at incidence of nodal metastases is confirmed. The next phase will be to look at

continued over

LATEST RESULTS OF THE PROJECT



A Great Meeting in Beijing

In September, I had a wonderful opportunity to attend China's 7th Annual Breast Cancer Treatment Training Programme organised by the National Cancer Institute/Hospital, Chinese Academy of Medical Sciences in Beijing. Over 70 junior clinicians specialising in surgical oncology from about 60 hospitals around the country were in attendance.

I was invited to present a seminar on my role as the Data Manager in the ACT & SE NSW Breast Cancer Treatment Project. I described how the Quality Assurance Project was set up, data collection and our most recent publication, the Five Year Report. The audience showed great interest in our Project.

I was impressed by the comprehensiveness of the program, which covered a wide variety of topics related to Breast Cancer Treatment in China. The program convenors are also interested in the development of breast cancer treatment around the world and they offer a warm welcome to Australia's breast cancer specialists to attend the program in future years. Anyone who is interested in this program, please contact me for details.

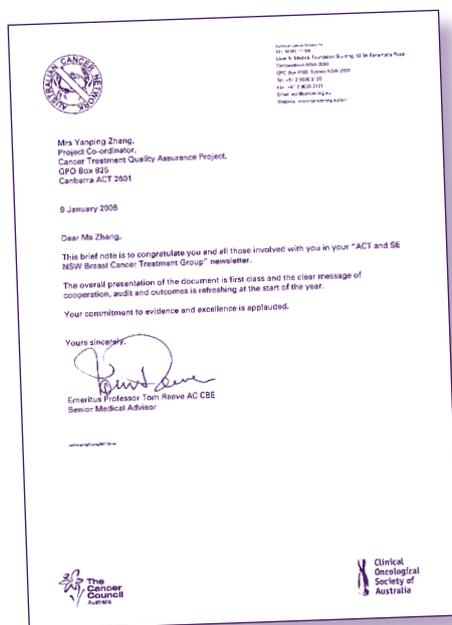
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Letter of commendation

In January 2006 the Breast Cancer Treatment Group received a letter of commendation from the Australian Cancer Network congratulating the group on its 2005 newsletter.

Emeritus Professor Tom Reeve AC CBE, Senior Medical Advisor commented that the overall presentation of the document was first class and the clear message of cooperation, audit and outcomes was refreshing.

"Your commitment to evidence and excellence is applauded," Emeritus Prof. Reeve said.



Multifocal Breast Cancer - continued

the effect of multifocality measured in three ways on the endpoints of loco-regional recurrence, progression-free survival, and overall survival.

This study will be the largest in terms of number cases of multifocal disease and is unique in its study of recurrence endpoints. Hopefully the results will contribute to a consensus on how the risk of this disease can be incorporated into our treatment recommendation algorithms.

This study would not have been possible if it were not for the hard work of Yanping Zhang and her team at the Project Office – thank you.

Endnotes

- 1 Andea A, Bouwman D, Wallis T, Visscher D. Correlation of Tumour Volume and Surface Area with Lymph Node Status in Patients with Multifocal/Multicentric Breast Carcinoma. *Cancer* 2004;100:20-7
- 2 Andea A, Bouwman D, Newman A, Wallis T, Dey J, Visscher D. Pathological Analysis of Tumor Size and lymph Node status in Multifocal/Multicentric Breast Carcinoma
- 3 Coombs NJ, Boyages J. Multifocal and Multicentric Breast Cancer: Does Each Focus Matter? *L Clin Onc* 2005;23:7497-502
- 4 Fish E B, Chapman J A, Link M A. Assessment of tumor size for multifocal primary breast cancer *Ann Surg Oncol*;5(5):442-6
- 5 Knauer M, Konstantiniuk P, Haid A, Wenzel E, Riegler-Keil M, postlberger S, Reitsamer R, Schrenk P. Multicentric Breast Cancer: A New Indication for Sentinel Node Biopsy – A Mult-Institutional Validation Study. *J Clin Onc*;24:3374-3380

Contact Details

If you have any enquiries or comments about the project, please contact the Project Co-ordinator.

Any clinical queries should be directed to Dr Paul Craft at the Canberra Hospital on (02) 6244 2220 or contact:

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> go to Breast Cancer Treatment



Robyn Bradley and Yanping Zhang



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