

## LETTER TO THE EDITOR

# Breast Care Is a Team Sport

To the Editor:

Every 2 minutes a woman is diagnosed with a form of breast cancer in the United States; one woman in seven. Over the last 30 years the incidence has risen by 1% per year, each year. Breast cancer occurs more frequently than lung cancer, colon cancer, uterine cancer, and pancreatic cancer combined (1).

Besides the increasing frequency, the size and stage of breast cancer has changed. Because of improved imaging, 29% of invasive breast cancers are 1.0 cm or less in size (2). Noninvasive cancers comprise 21% of new breast cancer cases (1). This profound change in presentation has led to a progressive decrease in the breast cancer death rate each year since 1992 (1).

Along with these changes, the treatment of breast cancer has become more complex. Management requires imaging to direct surgical treatment. Pathologic evaluation (grade, size, histology, margins, receptors, oncogenes, etc.) determines the options of local and systemic treatment. The heterogeneity of breast cancer becomes much more important when dealing with cancers smaller than 1.5 cm. A variety of care providers will interact with the patient as this course progresses. As the size of breast cancer decreases, the complexity of decision making increases, as does the number of people involved with patient care.

### BREAST CARE IS A TEAM EFFORT

Breast centers have the opportunity to bring together all the members of the breast care team to perform optimally. As the Olympics have recently shown, every member of a sports team is important for optimal outcome. Some sports are true team efforts, such as basketball and soccer. Other sports depend on individual effort, such as weightlifting or swimming. But even these individuals perform not only for their own personal goals, but also for the benefit of their entire team.

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Care of breast cancer patients similarly depends on individuals and small teams to achieve the best result. In the past, breast care used to depend solely on individual effort. Now, as the majority of cancers are nonpalpable and sentinel node sampling becomes standard, patients must depend on a coordinated interdisciplinary team to achieve a successful outcome. When the team is cohesive and focused, patients receive the best care.

### MILESTONES IN BREAST CARE

There have been several advances in breast care that have allowed today's successes, as noted in Table 1. Improved imaging modalities, including mammography, ultrasound, and magnetic resonance imaging (MRI), have optimized the preoperative identification of suspicious breast lesions. The median size of breast cancer has declined to less than 1.5 cm (2). As the lesion gets smaller, treatment can be less drastic, while overall outcome improves.

Another major advance is the use of needle biopsy instead of surgical biopsy. Emotionally women are better cared for when they can deal with the diagnosis prior to surgery. Likewise, the diagnosis by needle biopsy decreases repeat surgery and saves on overall cost (4).

**Table 1. National Consortium of Breast Centers: 10 Milestones and Promising Future Directions**

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Milestones
Lumpectomy equally effective as mastectomy
Development of needle biopsy rather than surgical biopsy
Development of sentinel lymph node procedure
Development of comprehensive breast centers working together as a team
Improved medications, including targeted therapies such as estrogen receptor modulators and chemotherapy agents
Improvements in imaging, including digital mammography, computer assisted, ultrasound, and MRI
Local and national organizations to improve breast care, both professional and advocacy
Genetic counseling, including genetic testing
Mammography Quality Standards Act
The Internet as a source of information and support
Promising Future Directions
Partial breast irradiation for breast cancer
Genomic and proteomic research and testing
Breast cancer ablation rather than surgery
Breast cushion for mammography

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Source: National Consortium of Breast Centers.

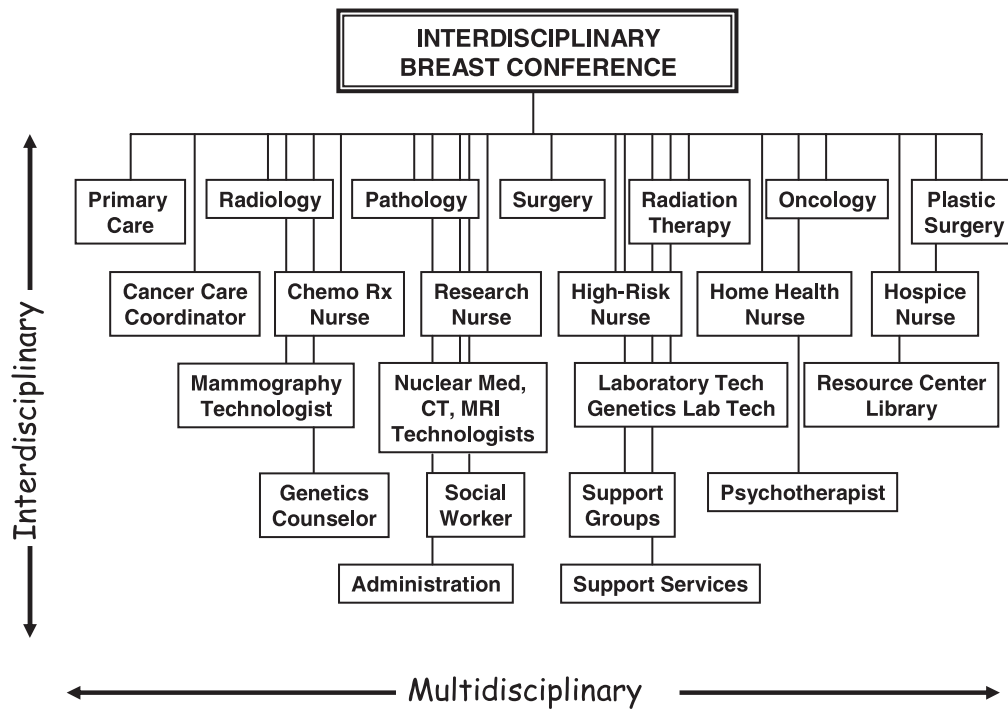


Figure 1. Interdisciplinary Breast Conference.

In the mid-1980s breast centers were developed around the country. Sites were called breast centers without regard to defined components of a breast center. Some were purely mammography facilities, while others offered more comprehensive services.

### INTERDISCIPLINARY BREAST CONFERENCE

As breast centers have matured, the cornerstone of these centers has been the interdisciplinary breast conference. This conference may go by various names, such as the pretreatment breast conference, comprehensive breast conference, tumor board, or simply breast conference. At these weekly meetings, all the members of the breast care team are present. Some arrive as individuals (surgeons, oncologists, plastic surgeons, etc.), while others arrive as small teams (mammographers, radiation therapists, nurses, social workers, etc.) (Fig. 1). When they meet in the same room and discuss individual patients, many barriers are broken and true progress is achieved.

The meeting allows consideration of all viewpoints of care for a specific patient. Each team member brings with them an array of choices that may be used to treat the patient. Gone are the simpler days of the 1991 National Cancer Institute Consensus Conference, which simply chose between lumpectomy and mastectomy (5). Gone

are the days when one physician would know all the details for available options to treat breast cancer.

At the conference, good ideas are validated, while less appropriate ideas are defeated in a collegial atmosphere. Unique findings of each breast cancer scenario are identified and modifications of standard treatments are considered. This is often the only time the surgeon, radiation therapist, and oncologist may directly view the histology with the pathologist. This conference provides an extra “second opinion” to each aspect of diagnosis and treatment, thus optimizing breast care.

A key distinction must be made between multidisciplinary and interdisciplinary teams (Fig. 1). Multidisciplinary teams usually refer to a group of different disciplines within one profession. For example, doctors of different specialties (surgery, radiation, pathology, oncology, etc.) would be multidisciplinary. In contrast, interdisciplinary teams refer to the interaction of different professions (doctors, nurses, technologists, social workers, genetic counselors, etc.). The interdisciplinary team considers the entire patient, from the type of axillary treatment to the value of genetic testing of family members.

Treatment discussions raise the skills of all who attend the conference. In addition, new areas of research may be mentioned for the benefit of the patient and the education of the rest of the team.

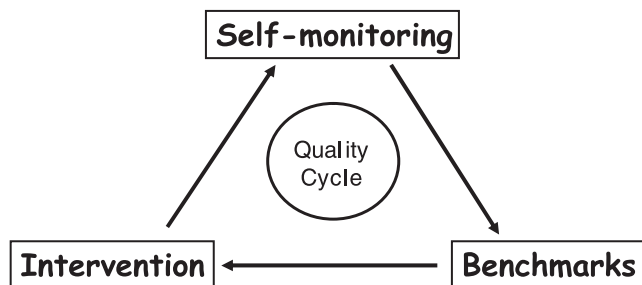


Figure 2. Quality Breast Care Cycle

Despite continued research, new therapeutic dilemmas occur. The breast conference is a forum where these questions can be debated for specific patients. A sample of recent questions discussed includes: How wide is an adequate margin for invasive or in situ disease? Is an axillary dissection necessary after the sentinel node shows a single micrometastasis? Is local excision with wide margins adequate for some in situ carcinomas? What is the optimal hormone therapy regimen after breast cancer? The questions go on and on. Without the treatment planning conference, these questions would be answered by a single individual without other input.

### WHERE DO WE GO FROM HERE?

Beyond the Mammography Quality Standards Act (MQSA), there are no formal guidelines or benchmarks as to breast center quality. Questions of wait time for a screening mammogram, time between mammogram and biopsy, likelihood of finding breast cancer at needle biopsy, frequency of reexcision after initial lumpectomy, sentinel node false-negative rate, etc., are not officially being asked. How does the breast care team improve?

Beyond teamwork, the goals of the team must be clear to all. With clear goals, monitoring our actions is the starting point for improvement. Take the example of the screening mammography call-back rate (6). The call-back rate cannot be improved without (a) knowing what your current call-back rate is (self-monitoring), (b) knowing what typical call-back rates are for your type of institution (benchmarks), and (c) improving those high or low call-back rates within your facility by giving needed feedback (intervention). The final phase of improvement is to monitor the results from feedback (self-monitoring) (Fig. 2).

This quality improvement cycle can be applied to many steps performed by the breast care team. A sample of quality questions asked by two centers focused on quality care (Tucker L, personal communication; Margolin F, per-

Table 2. Quality Questions for Breast Centers

Screen detection cancer rate
Group and individual screen detection rates
Wait times for appointments for screening, diagnostic, and image-directed biopsies
Percent of all cancers that are in situ
Percent of all cancers that are less than 1.0 cm
Ratio of percutaneous biopsy versus surgical biopsy
False-positive and false-negative screening rates
Impact of second reading
Node positivity for screen-detected and palpable lesions

Sources: Lee Tucker MD, Medical Director, Carilion Breast Care Center, Roanoke, VA; Fred Margolin, MD, Medical Director, Breast Health Center, California Pacific Medical Center, San Francisco, CA.

sonal communication) is noted in Table 2. Guidelines or benchmarks give the structure needed to identify what we are doing and how to improve.

Another quality issue is the varied use of surgical versus needle biopsy of breast lesions. Needle biopsy is associated with fewer positive margins at primary excision and less overall cost (4). Yet many surgeons still prefer surgical biopsy rather than core needle biopsy. The frequency of surgical biopsy versus needle biopsy can be identified by breast centers. Those performing excess surgical biopsies may be encouraged to choose a more efficient, less invasive, and accurate biopsy method.

Likewise, the efficiency of needle biopsy may be lost if it is excessively offered for very low risk lesions. The needle biopsy accuracy rate is monitored by many breast centers. A radiologist may recommend too many needle biopsies if the percent of cancers found at needle biopsy is only 5 to 10%. Similarly another radiologist might be missing some cancers if their percent cancer rate at needle biopsy is 40%. The quality breast center will monitor the needle biopsy positive cancer rate and give proper feedback.

There is a need to encourage breast centers to monitor their services for their patients' benefit. Without such self-evaluation, a center cannot continue to improve their services. The National Consortium of Breast Centers (NCBC) is developing a quality information survey for breast centers (7). Surveys of community, university, and free-standing centers (large and small) will be used to develop a variety of benchmarks. Individual centers can then compare themselves to centers similar to their own. With voluntary confidential surveys, overall care will be further improved for the breast cancer patient. Recognition of compliance with self-assessment will be offered by the NCBC. Further information can be obtained at [www.breastcare.org/quality](http://www.breastcare.org/quality) or by e-mail at [quality@breastcare.org](mailto:quality@breastcare.org).

### IMPROVEMENT CAN BE SEEN LOCALLY

My practice is in Washington State, the state with the highest rate of invasive breast cancer in the entire United States (8). In our state, like many others, we have seen a dramatic decrease in the breast cancer mortality rate, down 21% from 10 years ago (9). In my own county, the mortality rate has decreased by 28%, the average size of breast cancer has decreased by 17%, and the mastectomy rate has decreased by 47% (St. Joseph Hospital, Whatcom County, personal communication). Great progress has been made. Future improvements will depend on both individual and group efforts. As breast centers strive to work in harmony as a coherent interdisciplinary team, we will see much more progress in the next 10 years.

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