

Materials and Methods: Established in 2002, the Breast Health Global Initiative (BHGI) created an international health alliance to develop evidence-based guidelines for LMCs to improve breast health outcomes. The BHGI held two Global Summits in October 2002 (Seattle) and January 2005 (Bethesda) and using an expert consensus, evidence-based approach developed resource-sensitive guidelines that define comprehensive pathways for step-by-step quality improvement in health care delivery. The BHGI guidelines, now published in English and Spanish, stratify resources into four levels (basic, limited enhanced and maximal), making the guidelines simultaneously applicable to countries of differing economic capacities.

Results: The 3rd BHGI Global Summit in October 2007 (Budapest, Hungary) addressed guideline implementation in LMCs. 82 selected international experts working on four panels (Early Detection, Diagnosis, Treatment, Health Care Systems) discussed situation analysis tools and quality indicators to facilitate pilot project development in LMCs. Funded pilot projects have begun in Colombia and Indonesia. The BHGI guidelines provide a hub for linkage among clinicians and alliance among governmental agencies and advocacy groups to translate guidelines into policy and practice.

Conclusions: The breast cancer problem in LMCs can be improved through practical interventions that are realistic and cost-effective. Early breast cancer detection and comprehensive cancer treatment play synergistic roles in facilitating improved breast cancer outcomes. The most fundamental interventions in early detection, diagnosis, surgery, radiation therapy, and drug therapy can be integrated and organized within existing health care schemes in LMCs. Future research will study what implementation strategies can most effectively guide health care system reorganization to help countries that are motivated to provide better care to women in their country afflicted with breast disease and to improve breast cancer outcome among their populations.

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Invited

Breast cancer in emerging countries: The status of breast care in South Africa

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The apartheid system, which created an extremely efficient, high quality health service for a minority of the population, became untenable by 1990. Resources were then redirected to primary care at the expense of tertiary care. "Transformation" of the health service to allow "previously disadvantaged" population groups access to management positions denuded the service of experienced managers and was compounded by a succession of ineffective top officials. Deteriorating working and life circumstances and increasingly inadequate salaries led to emigration of professionals: A third of all South African nurses work abroad and half of all medical graduates emigrate upon graduation. In the underresourced public sector about 10% of medical doctors cater for about 80% of the population; breast cancer, despite being the most common female cancer, does not appear in the top 10 causes of women life years lost; the first 5 places are taken by AIDS, homicide, TB, diarrheal diseases and pulmonary infections. The incomplete statistics available generate the perception, that breast cancer is largely a "white women's disease" pushing it further down the list of priorities. Currently the country experiences about 8000 new cases of breast cancer, of which only about 2000 are catered for in 4 multidisciplinary centres offering in varying degrees state of the art diagnostics and therapy from BRCA testing, digital mammography to oncoplastic surgery, free tissue transfer reconstruction, neoadjuvant therapy with anthracyclin-taxane regimens and MeV radiation. To prevent further deterioration and reverse the trend, where there is still expertise is left it must be maximally exploited; public-private and South2South partnerships of apex institutions are to be formed. The North should accept an obligation to prevent uncoupling of 3rd world countries by maintaining active relations with apex institutions, sponsoring congress participation and support trial participation.

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Proffered Paper Oral

A health economic evaluation of follow up after breast cancer surgery – result from of an rct study

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Introduction: We studied the costs of following 264 breast cancer patients, stage I and II, randomised to two different follow-up programmes in a

prospective trial, involving, on the one hand, routine follow-up visits to the physician with follow-up visits twice a year or more over five years (PG = physician group), and on the other, specialist nurse intervention with check-ups on demand (NG = nurse group). The trial period was 5 years. The women in the two intervention groups did not differ in anxiety and depression, their satisfaction with care, their experienced accessibility to the medical centre or their medical outcome as measured by recurrence or death.

Patients and Methods: The analyses were done from different lists representing costs at three hospitals in Sweden according to the principles of a cost minimization study.

Result: The cost per person year of follow-up differed between the groups, with €630 per person year in PG compared to €495 per person year in NG. Thus, specialist nurse intervention with check-ups on demand was 20% less expensive than routine follow-up visits to the physician. The main difference in cost between the groups was explained by the numbers of visits to the physician in the respective study arms. There were 21% more primary contacts in PG than NG.

Discussion: The difference in cost per year and patient by study arm is modest, but transforms to nearly €9,000 per patient and 5-year period, offering a substantial opportunity for reallocating resources since breast cancer is the most prevalent tumour worldwide.

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Proffered Paper Oral

Does working in a multidisciplinary breast unit have any impact on surgical treatment?

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Background: Multidisciplinary treatment is the optimal approach to breast cancer. When it is performed in specialized units, it benefits patients and leads to more rational resource use. The European Society of Mastology (EUSOMA) published in 2000 their recommendations designed to provide a model for European high quality breast units (BU).

Methods: We analyze the results concerning surgical treatment, obtained from the survey about BU performed by the Breast Diseases Group of the Spanish Association of Surgeons, in 247 Spanish hospitals. Data of 167 (69.3%) answers were obtained. Analysis was undertaken using the Kruskal-Wallis test for quantitative and the chi-squared and Fisher exact tests for categorical variables; p-values of 0.05 or less were considered significant.

Results: Most BU (82) were managed by general surgeons, 70% of them specifically dedicated to breast diseases and near 40% with a postgraduate training in mastology. Clinical guidelines about diagnosis and treatment were used in 97.7% of BU. More breast cancer patients were diagnosed (112.6 vs. 69.4; p=0.004) and surgically treated yearly (96.8 vs. 55.5; p<0.001) in BU compared with hospitals with no BU. Breast conservation was performed in 55% of cases without differences concerning the presence of BU.

Sentinel node biopsy was more frequently adopted in the presence of breast unit (55 vs. 23; p<0.001), specially dedicated surgeon (54 vs. 18; p<0.001) and nuclear medicine facilities (40 vs. 33; p<0.001). In 90.3% isotopic or combined injection was used. Intraoperative evaluation of sentinel node was possible in 32.9%.

Postmastectomy reconstruction was performed by general surgeons in 41 BU. In most cases (37 vs. 13; p<0.001) reconstruction was immediately done as part of the initial treatment of breast cancer and by means of an implant (48.9%). Other reconstructive procedures as musculocutaneous flap techniques or oncoplastic approaches were less frequently completed.

Conclusions: Surgeons specially dedicated to breast diseases, working in multidisciplinary BU do more frequently use diagnostic and treatment protocols and guidelines, perform sentinel lymph node biopsy and postmastectomy reconstruction. These aspects are considered of high quality in breast cancer management and confirm the usefulness of establishing breast units.