SenoNetwork workshop

E6. Breast units: The need for a structured network

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Breast units are organisational tools designed to provide women with breast cancer with better treatment and interdisciplinary management of the disease. The concept of the breast unit (BU) was developed in the year 2000 by Eusoma, the European Society of Breast Cancer specialists, and it was followed by the identification of criteria to certify dedicated medical centres as centres of excellence for the management of breast cancer.

The number of certified BUs in Europe is growing; their names and contact details are available on www.eusoma.org. Also available on the same website are the criteria and procedures for said certification.

After the support of the breast cancer coalition, Europa Donna, the concept of BUs gained the mention of the European Parliament in 2003 and in 2006 as a recommended tool to be adopted by all Member States by the year 2016.

The European School of Oncology, a non profit organisation established in Milan in 1982 and dedicated to improving the knowledge and skills of health professionals in cancer care, joined Eusoma in 2007 in a common programme called Senonetwork[a], aimed at increasing the number of certified BUs in Europe and at assisting those who work in breast cancer centres and wish to be recognised as a BU according to the Eusoma rules.

The major changes in the treatment of breast cancer originated in the last 10 years from the fast growing knowledge of its biology. Until the 1970s we had been dealing essentially with four different settings: ductal and lobular carcinoma, in situ and invasive. Prognosis was nearly exclusively based on lymph-nodal status. The advent of hormone receptors has been the first major revolution in the approach to breast cancer, introducing the concept of hormone responsiveness and matching perfectly the discovery of tamoxifen.

Since then, in depth analysis of the disease has been constantly progressing and today any specialised pathology department will give at least eight different pieces of information on each case of breast cancer: histology and lymph-nodal status of course, but also exact size, grading, hormone receptor status, vascular invasion, proliferation index and cErbB2. As a result of this we can now have more than 100 different profiles of breast cancers, from the very “good” 1 cm lump of tubular carcinoma, G1, no vascular invasion, 100% receptor positive, Ki 67 5%, sentinel node negative and cErbB2 negative in a 65 year old lady, to the very “bad” 3 cm lump of ductal invasive carcinoma, G3, with vascular invasion, 0 hormone receptors, Ki67 60%, four metastatic axillary lymph-nodes and cErbB2 +++ in a 42 year old woman: two completely different diseases that we cannot approach in the same way anymore. In between are a number of different intermediate profiles to which it is expected that we will soon be able to add other information coming from the gene profiling assays.

This complexity of breast cancer makes an interdisciplinary and multiprofessional approach mandatory. The concept of BUs aims at responding to this need and it defines the characteristics of a specialised medical and nursing team fully dedicated to breast cancer, equipped with all necessary competencies (specialised pathologist, radiologist, surgeon, plastic surgeon, medical oncologist, radiation therapist, etc.) and technologies (sentinel node biopsy, surgical approach to non palpable lesions, core biopsy techniques, stereotactic procedures, specialised radiation therapies such as intraoperative electron therapy, partial breast irradiation, etc.).

Crucial to the level of performance is the critical mass, for the different aspects. Rightly or wrongly, Eusoma has established 150 new cases per year as the threshold to become a BU, 1000 mammographies a year to become a specialised breast radiologist and 50 surgeries a year, as first operator, to become a breast cancer surgeon.

It is the end of the “do it yourself” approach of the traditional surgeons and gynaecologists to breast cancer: too difficult to be dealt with occasionally, too dangerous for the patient to be treated outside a competent team.

The Senonetwork symposium at the 7th European Breast Cancer Conference in Barcelona will be held on 24 March 2010 and will start with an interesting report from the Netherlands dedicated to the Dutch experience in improving quality in breast cancer care, followed by two sub sessions, one on breast cancer patient support and one on data collection. Particular attention will be given to breast care nursing and to psychological support, particularly at time of diagnosis.

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[a] The Senonetwork meeting is jointly supported by the European School of Oncology (ESO) and the European Society of Breast Cancer Specialists (Eusoma).

1359-6349/$ – see front matter

What patients demand is not to be informed by phone, nor in a rush and not in an uncomfortable environment. Aren't they right? A patient waiting for her pathology report is inevitably in a constant state of anxiety: the doctor's phone call is at a high risk of finding her at the wrong moment to receive the news. Doctors should learn (and insist on having the right) to resist the temptation to "gain time" by telling the patient their pathology results whilst standing in a corridor or in front of a lift which they are going to take a few seconds later. The doctor should properly plan this very important moment, be ready to dedicate the necessary time to it without answering the phone or being distracted by other people and the patient should be told not to come by herself, be invited to read in advance the report or to have a copy in front of her during the explanation. She or her caregivers may have spent hours making the setting perfect: if things are done well at the time of the communication of the diagnosis the patient will never forget it and everything will also be easier for the oncologists (doctors and nurses).

It is also time to accept that medical language is often strange and sometimes bizarre. Why do we still need latin words like *in situ*? Shouldn't we support the proposed new classification of breast cancer which replaces DCIS with DIN (Ductal Intraepithelial Neoplasia) and LCIS with LIN (Lobular Intraepithelial Neoplasia): lay people associate the word *carcinoma* to *cancer* per se, so why keep calling carcinoma what we also define as a pre-cancerous lesion? At that stage we could simply call *ductal* and/or *lobular carcinoma* what we now have to define as *invasive* or *infiltrating*; very scary words to the ears of anybody. And why do we still use (in many languages) the word *positive* to mean *with cancer* ("positive" lymph nodes to mean *metastatic*) and *negative* to mean "all is well"? Before meeting us, people thought that positive was good and negative was bad. Therefore, it's a bit strange and confusing what doctors may tell a patient. There is a great need for improvement of communication.

The sub session on data collection will focus on all aspects of data management and data monitoring in a BU, with the aim of producing a solid database containing correct information on the whole activity of the unit. Data collected by the different Eusoma certified BUs are subsequently sent on a yearly basis to the central database for evaluation of the quality indicators (which probably, at the moment, is the best way of controlling the clinical performance of these groups and protecting breast cancer patients from individual and too subjective decisions.

Conflict of interest statement

None declared.