similar local and regional recurrence rate as mastectomy. In this study, we compared the risk of locoregional recurrence (LRR) for patients treated with breast-conserving surgery with patients who underwent mastectomy in a population-based study and identified predictors for LRR in this setting.

Methods: From the Netherlands Cancer Registry, we retrospectively identified 1,312 women who were diagnosed with primary invasive breast cancer (T1−2, N0−1, M0) between January 1, 2002, and December 31, 2003, and who underwent surgical treatment for their disease within the region of Middle Netherlands. Our primary endpoint of interest was LRR isolated or with distant metastases after five years. Predictive factors for LRR were determined by univariate and multivariate analyses.

Results: Overall, 49 patients (3.7%) had a LRR within five years after surgical treatment, and 24 of these patients also developed distant metastases (49.0%). After five years, LRR was more common in women who had mastectomy (5.3%) compared to patients who received breast-conserving surgery (2.5%; $p = 0.008$). All participating hospitals ($n = 6$) were able to achieve favourable rates of LRR with conservative surgery. The results of multivariate analysis showed that higher stage and omitting radiotherapy are risk factors for LRR.

Conclusions: Our population-based study shows that both academic and community hospitals are able to achieve low rates of LRR in breast cancer patients treated with conservative surgery compared to patients who underwent mastectomy in the first five years following breast surgery.

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A national audit of breast cancer follow-up patterns in Wales

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Background: United Kingdom NICE clinical guidance for early and locally advanced breast cancer (February 2009) recommended that patients should be followed up with annual mammograms for a maximum of 5 years. Evidence has shown that routine follow-up over and above 5 years has little benefit as recurrence commonly occurs within the first 3 years and is usually symptomatic. The aims of the audit were to assess the current breast cancer follow-up practice in Wales

Method: A unique questionnaire was constructed and e-mailed to all consultant breast surgeons in Wales. If the consultants failed to respond, a telephonic interview was conducted with a breast care nurse within the unit.

Results: Our results showed that there is no unified approach to follow-up of breast cancer patients within Wales. The duration of follow-up varied from ten years, until the age of 50, until the age of 50/five years (whichever was sooner) or until the age of 50/ten years. In younger patients (aged <40), 15 consultants used mammography to screen the contra-lateral breast after mastectomy in patients, while 5 preferred MRI. Breast units followed-up young cancer patients with MRI in north Wales but mammography in south Wales. Breast units in south-west Wales offered yearly mammograms until the age of 50 for younger patients and five years for all others, while those in south-east Wales had the most varied and prolonged follow-up protocols. Older consultants also tended to follow-up their patients for longer periods.

Conclusion: There are wide geographical differences in breast cancer follow-up throughout Wales. We recommend a unified protocol, based on NICE guidelines, of annual review for five years, and access to breast clinic only in the presence of new symptoms.

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Breast cancer care and outcomes in 18 countries in Europe, Asia, and Latin America

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Background: Although breast cancer has a better prognosis than many other cancer forms, with long-term relative survival rates of up to 80% in some countries, the burden of breast cancer is considerable both in terms of suffering for patients and economic burden to society. Survival still differs considerably between countries that appear to have comparable resources dedicated to healthcare. This study reviews best practices and discuss what is crucial for the development of optimal breast cancer care in relation to available resources in different settings.

Material and Methods: A review of literature and public databases was performed, clinical experts were consulted and a survey was administered to previous and current breast cancer patients.

Results: The lack of clinical and epidemiological data in many countries is a limitation when estimating the burden of disease, identifying trends in cancer prevention, care, treatment and outcomes over time as well as when making inter-country comparisons. Guidelines for the organisation and treatment of breast cancer are available in almost all the study countries, but only monitored in a minority of countries. We found a 15× variation in breast cancer care spending per capita; a variation in 5-year survival from 55−90%; a variation in screening attendance from 15−90%; a variation in access to radiotherapy of 10×; and variations in access to breast cancer drugs: tamoxifen of 5× and trastuzumab of >10× (radiotherapy and drug access adjusted for breast cancer incidence). Feedback from patients and patient groups included a need for more information about treatment options and greater focus on quality of life aspects. This especially applies for women with metastatic breast cancer, where so far limited improvement in outcome has been seen.

Conclusion: There is a need for registries that capture not only incidence and mortality but also treatment patterns in relation to more specific outcome measurements. In order to achieve high quality and equal care, guidelines need to be evidence-based, regularly updated and monitored. It is essential that regulations, funding, and care organisation are coordinated to provide all patients with the most appropriate, cost-effective and evidence-based treatment with minimal delays.

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Policy cost-effectiveness of a hospital-tailored multi-faceted implementation strategy for introduction of a short stay admission programme following breast cancer surgery

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Background: Aim of the study was to assess the policy cost-effectiveness of a short hospital stay programme following breast cancer surgery after implementation of the programme. Costs and effects of a short stay programme were combined with costs and effects of an implementation strategy to calculate policy cost-effectiveness.

Material and Methods: The analysis was performed alongside an implementation study and took a societal perspective with a five-year time horizon. The implementation strategy was multi-faceted, and tailored to the needs of each of the four participating hospitals. The study period spanned from December 2004 until December 2007. The effectiveness of implementation was defined as the uptake of short stay admission. Cost data on development and execution of the implementation strategy were obtained from healthcare professionals, and were added to costs of the short stay programme to calculate total policy costs. Policy cost-effectiveness of the short stay programme versus care as usual was expressed as the incremental costs per Quality Adjusted Life Year (QALY).

Results: The uptake of short stay admission was 36%. Implementation costs were €23.− per patient. As QALY differences were marginal, an ICER could not be calculated. Bootstrap analysis revealed that the short stay programme had a probability of 93%-89% of being cost-effective irrespective of the ceiling ratio. From the healthcare perspective, the policy was significantly cost-saving.

Conclusions: With incorporation of costs and effects of implementation, the short stay programme was cost-effective from a policy point of view. We advise large-scale implementation of the short stay programme based on the results of this study.