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Should specialist breast units be adopted in Europe? A comment from Europe

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The European Society of Mastology (EUSOMA) position paper on (pp. 2288–2293) sets out the requirements for European breast units as laid down by a EUSOMA subgroup comprising 21 representatives from eight European countries. The recommendations of the report represent a policy statement of three major European organisations: EUSOMA, the European Organization for Research and Treatment of Cancer (EORTC) and Europa Donna. The paper sets out clearly defined guidelines which aim to move rather heterogeneous practices in European breast units towards a more unified practice, which aims to raise treatment and diagnosis standards across all units. Similar standards have already been published in the UK over the last 5 years, and have been widely adopted by both clinicians and health managers as good templates for raising standards. After a debate held at the recent Florence meeting, the floor concluded that standards should also be drawn up for European breast units, hence the appearance of this document.

The general recommendations should receive widespread support as they aim to give patients a prompt and efficient diagnosis by breast specialists, although the suggestion that some small hospitals should close their breast unit if it is below a caseload of 150 new breast cancers will not be popular. The argument that a caseload of 150 cases is the correct figure is not supported by direct evidence (however, the relevant research has not been done), and the case is based more on consensus and cost, as the multidisciplinary team approach is expensive in people and equipment and would be less suitable for a low caseload clinic. There is indirect evidence that specialisation, which is associated with an increase in a caseload, is beneficial [1] and the principle of the concentration of cases is accepted in other settings, e.g. children's cancers and other rare cancers. Currently there is a Research & Development study in the UK which is examining the interactions in differently sized multidisciplinary teams and results will be presented at the November BASO meeting in London.

The mandatory requirements setting out team membership may be more difficult to implement in countries where medical systems are based on individual or private office-type practice, but this is not a reason to lower the standard as systems without audit and accountability should be changed so that the results of treatment of breast cancer are available throughout Europe on a comparative basis. This has been implemented in the annual BASO review of the results of the British Screening Programme [2] which has allowed direct comparison between different units. For example, this annual audit has shown that approximately 13% of patients with invasive breast cancer do not have axillary staging performed and some patients undergo multiple operative procedures in order to make a diagnosis. These anomalies can then be corrected after the identification of the reasons for the departure from the protocols of management.

In the document by EUSOMA, the definition of the team and the process of diagnosis seems to be reasonably described, although the key to progress will rely heavily on the availability of good quality information. This explains why a data manager must be an integral member of the team and it would be a major advance if a common database could be agreed upon Europe-wide (or at least a common minimum data-set).

The need for the availability of reconstruction is unquestioned, but in some countries there may be problems with the integration of reconstruction provided by plastic surgeons (often delayed procedures) and the modern developments of onco-plastic surgery delivered by breast surgeons which encompass delayed immediate procedures. More data are required in this area, and

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close collaboration with good outcome data will help patients and surgeons in the choice of the right technique for the individual patient.

Family history referrals form some 10% of all breast unit referrals in the UK, whereas the cancer detection rate in this group is quite low, i.e. 3–5 cancers per 1000 prevalent mammograms. Thus, the workload is high in terms of consultation time, but not for operative time. Recent studies have indicated that breast surgeons can adequately reassure these patients and joint consultation may only be needed for very high-risk patients [3]. These patients will need access to both genetic testing and prophylactic management approaches. There can be little argument with the aims of this document to raise the standards of diagnosis and management of breast cancer, but the most controversial recommendations of caseload and multidisciplinary team work are currently consensus-based. The problems of small population densities will need to be solved constructively as patient access is a variable that must not be forgotten. However, most patients offered a higher quality service a long distance away are usually prepared to travel to obtain it and it should not be forgotten that breast cancer as a primary presentation can only affect a woman twice in her life. It should be clearly recognised that prompt diagnosis with optimal surgical and medical treatment, and not careful follow-up, gives the best mortality outcomes, and it is likely that the recently reported improvement in the USA/UK mortality is due to improved diagnosis and treatment [4]. This document outlines a reasonable structure to deliver these aims.

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