

**NATIONAL CO-ORDINATING COMMITTEE FOR
QA RADIOLOGISTS (“BIG 18”)**

Minutes of the meeting of the National Co-ordinating Committee for
QA Radiologists held on Wednesday 10 December 2008

Present

Dr R Wilson	Chairman
Dr J Liston	Secretary
Dr G Briggs	N.Ireland
Dr J Cooke	South East Coast
Dr A Evans	East Midlands
Dr R Given-Wilson	St George’s Training Centre
Dr K Gower Thomas	Wales
Dr A Hubbard	Equipment Sub-group
Dr J Lavelle	Greater Manchester/Lancs/Cumbria
Dr P Loynes	West Midlands
Dr M Michell	London + RCR Breast Group
Dr C Record	South Central
Dr W D Thompson	NEYH
Dr M Wallis	NIB
Dr F White	Mersey/Cheshire
Dr R Whitney	Eastern
Dr M Wilson	Manchester Training Unit

In Attendance

Dr L Smart	Scotland
Mrs S Sellars	NHSBSP

Apologies

Dr K Duncan	Scotland
Dr E Kutt	South West
Dr P Nisbet	Jersey
Dr A O’Docherty	Dublin
Mrs J Patnick	NHSBSP

1. Minutes of last meeting held on 02 July 2008

Minutes amended to read Dr J Cooke represents South East Coast not South East-East.

The minutes were otherwise agreed as an accurate record.

2. Matters arising

a. Non -operative diagnosis of screen detected cancer/multidisciplinary meeting

A meeting has been arranged by JP on 15 January 2009 with three radiologists (RW/MW/AE) plus three pathologists and three surgeons.

RW agreed to request that at least one of the three pathology representatives is involved in reporting breast cytology.

Action: Robin Wilson

b. New NBSS Clinical Module

WT has contacted the National Screening Office and requested that the clinical summary sheet is amended so that it can be used as the referral letter to the surgeon. Sarah Sellers unaware so WT agreed to re-submit and copy to MW. SS reported that an NBSS User Survey was currently being analysed and any suggested changes to the clinical module would be considered collectively.

Action: Will Thompson

c. Private Base Screening Practice

As many private providers now provide only initial screening, women requiring further assessment are seen in NHS clinics. Difficulties arise as not infrequently the initial imaging is not available at the time of assessment.

It was agreed that the RCR Breast Group and Big 18 draft guidelines to be presented at the next Big 18 meeting. Guidelines should include what all women who access private screening should expect e.g. a) Assessment within the same time frame as that provided by the NHSBSP b) Copies of screening films in a readable form (ideally hard copy) should be available at the time of assessment etc. Once guidelines agreed they would be sent to all private providers, breast radiologists and cancer charities for inclusion on their websites.

Action: Mike Michell /Robin Wilson

3. Workforce/Reading Methods/Recall Rates

RG-W presented data which was subsequently circulated on 12/12/08. Double reading with arbitration is the only intervention shown to increase cancer detection and reduce recall rate. Currently there is no good data on the exact type of double reading being undertaken by individual units e.g. arbitration only in discordant cases, arbitration of all recalls etc. Successful programme expansion is dependent on recall rate target compliance. It was agreed that RW should ask the National Office to fund a survey of screen reading practice. RG-W and MW agreed to co-ordinate the survey. QA leads should collect their local data.

**Action: Robin Wilson /Ros Given-Wilson / Matthew Wallis
/ QA Radiologists**

4. 62 Day Target

The clock starts on the day of definitive recall to assessment i.e. date of the final read that generates the recall to assessment (arbitration read or consensus). Time to treatment will be monitored from January 2009.

5. Update on Extension of Screening Pilot

Study awaiting MREC approval. Six pilot sites have been identified (Kings/Coventry/Cambridge/Bolton/Guildford/Manchester). The National Office have sent letters of intention to these sites and asked them to screen 47-50 yr old women initially, pending the outcome of the MREC submission. If the randomisation method is approved they will then switch to the batch randomisation method of invitation. The Oxford Research Group have developed a patient information leaflet.

6. Cancer Reform Strategy

An update on implementing the Cancer Reform Strategy is now on the DOH website.

A cancer epidemiologist has been appointed by the Advisory Committee for Screening to look at the management of all women within the screening age group including those with a past history of breast cancer. The findings will then be used to inform policy on the follow-up of women with breast cancer.

NICE Guidelines due to be published in February 2009 will state that optimal follow-up is not known (versus the recommendation of annual screening follow-up as suggested in the draft NICE Guidelines).

7. KC62/3 Revision

These will include: -

- a. New table H for high risk women.
- b. Sub-divided into three age bands.
- c. Non-operative diagnosis target for both invasive + non-invasive disease.
- d. Number of nodes positive / number of nodes negative / number of nodes negative with sentinel node biopsy.
(Nodes diagnosed as positive pre-operatively can also be recorded).

8. NBSS

Interface piloting going well at NBSS end. The outcome of Change Control Notices submitted to Local Service Providers to add breast screening to their PACS. This will involve further piloting with LSP PACS.

Day book encryption works OK but it was noted that the DoH requires re-encryption every 2 months so units will need additional laptops.

Coventry will go live in late December with mobile worklists and desk synchronisation.

A PowerPoint presentation written by Sarah Sellars entitled "Update on Developments and Challenges: PACS and programme expansions" was circulated after the Big 18 meeting on 30/12/08.

John Orrell at Temenos has drafted a specification for high risk screening. This will be finalised by a small multidisciplinary working group which includes MW.

In women treated with neoadjuvant chemotherapy the tumour size should be taken from the radiology measurement and the grade from the pre-treatment core biopsy.

9. Breast MRI Surveillance Guidelines

Lindsey Turnbull has responded in detail to the circulated draft. It was agreed that: -

Protocols for actually undertaking MRI could be less prescriptive.

Screening MRI and mammograms should be interpreted together with knowledge of the other examination.

Ideally one of the two readers must have screen reading skills (reading >5000 cases/yr). RW agreed to redraft the guidelines and to send them to the National Screening Office.

Action: Robin Wilson

10. Ultrasound QA Guidelines

To help radiologist decide when a machine is no longer suitable for use it has been suggested by the medical physics that in addition to the current QA tests a clinical log book should be provided for each machine so that radiologists may log comments.

11. Atypia Reporting on B3 Cores

All agreed that the reporting of the presence of epithelial atypia associated with radial scars, papillomas etc. should be routine so that suitable cases can be selected for VACB. RW agreed to contact Prof Ellis.

Action: Robin Wilson

12. Screening Disabled Women

The results of a pilot study undertaken in Liverpool and previously circulated were discussed. There was agreement that if 50% of the breast tissue could be imaged then it was reasonable to proceed with the exposure for mammography. This will need to be included as an appendix in IRMER guidelines.

Action: Sarah Sellars

Further refinement is needed re: the wording of results letters and individual units will need to flag cases as either “incomplete screen” or “attended but partial screen”.

13. Private Thermal Imaging

Liz White reported that a private thermal imaging clinic had been set up claiming to detect breast cancer 8-10 yrs before mammography. The advice from the group was that LW should inform her local Trading Standards.

Action: Liz White

14. Training/Development Lead, RCR Breast Group

This post has been introduced so that it can be ascertained exactly what provision for breast imaging training has been made within training schemes around the U.K. It was felt that it was optimal to expose trainees to some aspects of breast imaging in years 1 and 2. The new appointment would liaise with the RCR Big Professor who would then visit units where there was currently little interest being shown in training as breast imaging radiologists.

15. Reports from Other Groups

a. QA Directors

RW reported the group met 3 weeks ago and discussed programme extension, screening extension pilot sites, recall rates, slippage and Interval cancers.

b. ACBCS Committee

RW reported that this meeting, chaired by Valerie Berel, met for the first time in 18 months. Louise Izatt gave an update on gene defects and a paper on breast cancer risk. Lars Holmberg has been asked to lead a group to advise on how higher risk groups should be managed once they reach the age for screening invitation. Ian Ellis gave a paper on the risks associated with LCIS and other pathology risk lesions. Initiatives to encourage ethnic minority groups to attend screening were discussed. A group led by Amanda Ramirez has been asked by Julietta Patnick to survey the attitudes of women regarding where and how they are screened i.e. mobile versus static sites. Kate Gower-Thomas reported that Wales would like to operate from 19 static sites instead of 120 mobile sites. The views of 3,800 women were canvassed and around 40% said “no” or “not sure” when asked if they would visit a new site (results of survey circulated on 12/12/08).

c. BASO (summary provided by WT)

Discussion over the future of ABS and BASO-ACS

ABS is a sub-group of BASO-ACS but has grown to such a degree that it dwarfs the parent group. Discussions were around whether or not the ABS should break away and, if it did, about the future viability of ACS. It was further complicated by the position of BAPRAS in a breast cancer orientated group. Members' views are to be sought by questionnaire.

Programme expansion

The group continued to express uncertainty over the proposal to treat the age extension as a study.

Revised guidelines

Screening guidelines and symptomatic / treatment guidelines have been "harmonised". There is continuing debate over margins, axilla and local recurrence rates. A non-operative diagnosis target for DCIS of 85% has been proposed. A patient representative will be invited to attend future guideline revision meetings.

d. National Imaging Board

Issues around private screening were discussed. All imaging examinations must be put on PACS including those from mobile ultrasound machines and be reported.

16. Any Other Business

a. Survey of Breast Radiology practice (summary provided by MM)

Results of a survey of UK Breast Radiology Practice were tabled. A questionnaire had been sent to all members of the RCR Breast Group and 128 replies had been received. These had shown that approximately one third of radiologists were not fully compliant with current NHSBSP guidelines. During discussion, JP clarified that the existing standards should be adhered to until there is evidence to the contrary.

Actions :

- 1. Regional QA radiology leads to discuss with colleagues at QA meetings.**
- 2. Form to be revised and circulated ? via QA leads to obtain further data from a larger sample of radiologists.**

b. Evaluation Group

Roger Blanks had expressed anxiety over interval cancer data quality with multiple data entries etc. Radiologists should encourage QA Reference Centres to collect accurate interval cancer data.

c. Infection Control.

Mary Wilson reported that her Trust insisted that disposable core biopsy guns were used. This had made accurate biopsy of some lesions more difficult.

d. National Equipment Group - Trailer Specifications

Ann Hubbard reported that the new specification for digital trailers was being developed. This would be used for setting up the framework agreement with NHS PASA. The specification and guidance notes would be published on the NHSCSP website.

Date of Next Meeting

Wednesday 01 July 2009