

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

Minutes of the meeting of the National Co-ordinating Committee for
QA Radiologists ("Big 18") held on Wednesday 2nd July 2008

Dr R Wilson	Chairman
Dr J Liston	Secretary
Dr J Cooke	South East-East
Dr K Duncan	Scotland
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 E Kutt	South West
Dr P Loynes	West Midlands
Dr M Michell	London + RCR Breast Group
Dr P Nisbet	Jersey
Dr W Thompson	NEYH
Dr M Wallis	NIB
Dr F White	Mersey/Cheshire
Dr R Whitney	Eastern
Mrs J Patnick	NHSBSP

In Attendance

Rachel Bennett	CSEU
Hazel Scott	PERFORMS

Apologies

Dr G Briggs	N.Ireland
Dr J Lavelle	Greater Manchester/Lancs/Cumbria
Dr A O'Docherty	Dublin
Dr C Record	South Central
Dr M Wilson	Manchester Training Centre

1. Minutes of last meeting held on 12th December 2007

The minutes were agreed as an accurate record.

2. Matters arising

a) Gold standard PERFORMS readers

The criteria suggested in last Big 18 meeting minutes do not allow selection of sufficient numbers of gold standard readers. Currently PERFORMS are using the following criteria:-

1. Still use existing RO experts.
2. Those who have been reading for over 7 years
3. Those reading at least 200 cases per week.
4. Those who have scored over the mean for both recent sets of PERFORMS.

5. Must have near average to average scores on the previous two sets of PERFORMS for sensitivity.
6. For all previous sets undertaken they must have a generally high record on Sensitivity and have sensible CS scores.

b) London audit of axillary ultrasound

Mike Michell has circulated audit and other units are contributing data.

c) ABS at BASO non-operative diagnosis audit

The 06/07 audit has been circulated and identifies most units by unit code (following the meeting the National Screening Office circulated code identifiers). JP will arrange for audit to be put on NBSS website.

Action: Julietta Patnick

In one unit in NEY&H, one unit in SE Coast and three units in N.West Region a significant number of cancers were diagnosed by C5 cytology alone. As mastectomies should not be undertaken on the basis of C5 cytology alone and a cytological diagnosis of malignancy does not establish a non-op diagnosis of invasion versus in-situ malignancy it was recommended that the QA Reference Centres investigate why such high proportions of cancers are still being diagnosed on the basis of C5 cytology alone in these four units.

Results show little change over the last 3-4 years. The consensus view was that there needs to be improvement in the non-operative diagnosis rates for in-situ cancers. This may be achieved by increased use of VACB. It was recommended that QA teams look at:-

Calcium retrieval rates

Number of cores taken

B3/4 rates

Establish if units have access to VACB + if consumables are adequately funded so that VACB may be used to maximum effect?

In 4 units the proportion of cancers with a B5a core biopsy later found to have an invasive component (non-op understaging) was significantly higher than the average rate of 22%. Regional QA Reference Centres should carry out audits in these 4 units to ascertain the reason for these unusual results. 2 of these 4 units also have low non-op diagnosis rates for invasive cancers. This is an important multidisciplinary issue and communication between the surgeons and other disciplines particularly pathology and radiology needs to be improved to ensure the audit loop is closed (not all relevant QA radiologists were aware of these 4 units until contacted by MW). Achieving a non-operative diagnosis in screened women is primarily a task undertaken by radiologists although it was noted that the surgeons are proposing new non-operative diagnosis targets be included within revised NHSBSP Surgical Guidelines.

JP agreed to convene a multidisciplinary meeting and will contact Ian Ellis (Pathology QA chair) and Martin Lee (Surgical QA chair).

Action: Julietta Patnick

JP informed the group that a National Cancer Intelligence Network is being set up. Gill Lawrence is the lead for breast cancer (screening + symptomatic). A publication pulling together many of the UK data sets is anticipated.

d) NHSBSP Training Centres update

JP has been asked to comment on a draft document produced by a group of SHA Training Commissioners. The document is intended to identify national specifications against which SHAs could commission training.

3. PERFORMS - Real Life Study

Hazel Scott gave a most interesting presentation comparing Real Life performance of screen readers in the East Midlands Region versus their performance in PERFORMS. Andy Evans is the lead author for a paper currently being prepared using the data. Handouts were distributed. In summary:-

- Similar proportions of cancer types are correctly identified in PERFORMS and in 'real-life' breast screening (as a first reader).
- Correlations between PERFORMS measures (TP, TN, FP, FN) are generally correlated with most breast screening data.
- PERFORMS is an educational tool
- Skill on PERFORMS generally reflects how an individual is performing in breast screening, but is not always wholly representative of every aspect of an individual's real life performance – a strong indicator rather than an absolute measure.
- Continued use of this scheme highlights potential areas of difficulties.

4. National QA Audit Results 06/07

Data presented by Rachel Bennett was discussed.

75% of units are not achieving the expected target recall rate for women attending their prevalent screen. JP is concerned that women will be reluctant to reattend when reinvited for screening if they experience a false positive recall after their first screen. Although there is known correlation between low recall and low cancer detection rates there is no known correlation between high recall rates and high cancer detection rates. It was recommended that units with prevalent round recall rates > 10 % (i.e. exceeding minimum target) should consider reviewing/ arbitrating all recall cases even if the opinion of the 1st and 2nd reader is concordant. After discussion it was agreed that there was no value in producing graphs plotting results against round length but further investigation

is needed if units with round length slippage also have low cancer detection rates.

It was agreed to recommend changing the incident round benign biopsy rates to:-

Minimum target < 1.0 (versus <2.0)
Expected target < 0.75 (versus <1.0).

The mean value for prevalent SDR was 1.48 and incident SDR was 1.30. Views were expressed as to whether increased HRT use had contributed to the mean incident SDR now being lower than the mean prevalent SDR.

5. Cancer Reform Strategy update

There is no national capital allocation for the purchase of digital mammography machines. Mike Richards has written to the Secretary of State and there have been letters from charities and parliamentary questions as using digital equipment is a requirement for screening women <50 years. AH suggested setting a lower target dose for younger women to discourage the installation of CR instead of full field digital equipment as the dose associated with the latter is significantly lower. A framework for central procurement of digital equipment has already been agreed. Units are advised meanwhile to continue developing business cases.

NBSS is continuing negotiations with Connecting for Health so that screening is spine compliant.

JP advised that an inequalities committee has been set up by the DoH to develop a strategy to address screening uptake variation.

There has been no further progress in developing a national screening tariff. MM concerned that a tariff for women screened versus women invited would disadvantage units with low uptake. RW of the opinion that tariffs for VACB should be unbundled from the basic tariff. Some units are charging VACB as day case surgery attracting fees of £960 per case. Resources for screening high risk women including MRI are held by PCTs.

6. 62 Day Target

The DoH is attempting to align the 18 week wait target definition eg. on clock "pausing" with the 62 day cancer wait target definitions. The 18 week target starts on receipt of referral. Supplementary guidance is expected defining the start date for screened women. Needs approval from Information Standards Board which will next meet in July 2008. Direct input of screening data will facilitate validation of key dates. Implementation is expected by December 2008.

7. **Extension of Screening (47-73)**

A protocol to undertake a pilot study randomising screening women aged 47-50 and 70-73 is being written by Valerie Beral, Sir Richard Peto and colleagues for submission for ethical approval.

8. **Breast MRI surveillance guidelines**

The draft MRI surveillance guidelines previously circulated were discussed. It was agreed:-

- a) Remove the paragraph re: HRT
- b) Units should follow RCR and local Trust's policies regarding requirement to assess renal function prior to gadolinium injection.
- c) Information leaflets are needed for both mammographic and MRI screening of (familial) high risk women which include the statement that there is no current evidence that screening will result in mortality reduction so that women can give implied consent.

Action : Julietta Patnick

- d) MRI studies should be double read and one of the readers must be a screen reader working to NHSBSP standards.
- e) If 2nd look ultrasound is required women should be recalled to an NHSBSP Assessment Centre.
- f) If 2nd look MRI is required it should be undertaken 6 weeks not 6 months later.
- g) Need a few designated centres doing MRI guided Bx (minimum of 12 MRI Bxs per year but not necessarily doing >100 VACBs per year). Agreed that biopsy method should be VAM.
- h) Need a small number of centres with high levels of expertise to undertake screening MRI.

RW agreed to update draft guidelines.

Action: Robin Wilson

JP will advise SHA screening leads of the need to set up MRI screening and Bx services in each Region.

Action: Julietta Patnick

9. **Categorising interval cancers in women aged 65-70**

At a recent London QARC workshop to discuss classification of interval cancers, there was uncertainty amongst the data managers re: a scenario where a woman was screened in Feb 1999 but not reinvited in Feb 2002 as she was then outside the 50-64 age range. The unit extended screening to women aged 50-70 in Oct 2002. She was diagnosed with cancer in Nov 2005. All agreed that she should be classified as an interval cancer as she was diagnosed > 3 years after the

service expanded its age range. It was emphasised however that this was a programme failure not a radiological one.

10. Reports from other groups:-

a) QA Directors

All topics discussed included in this agenda.

b) ACBCS committee

Not met since last Big 18 meeting.

c) BASO

Martin Lee is now chairman of BASO. Discussion included review of the BASO constitution, the Cancer Reform Strategy, harmonisation of surgical screening and symptomatic guidelines and the requirement for assessment of the axilla with ultrasound +/- needle bx in women with breast cancer.

d) National Imaging Board

Matthew Wallis or Erika Denton will be invited to attend Big 18 meetings to provide a link with the National Imaging Board. Current issues include making NBSS spine compliant.

11. Sensitivity of Screening Post Augmentation

RW has written to BASO and the Royal College of Surgeons. No response expected. Discussion suggested that retromuscular implants actually do make mammography easier ?

12. Private Based Screening Practice

RW has had informal discussions with some of the large private providers re:assessment being an integral component of screening. Women requiring assessment should attend either a NHSBSP Assessment Centre or a private unit operating to the same standards with appropriate staff and equipment. All radiologists agreed that assessing screen detected abnormalities within a symptomatic clinic is less than ideal. RW agreed to continue discussions with private providers.

Action: Robin Wilson

13. Regional variation of national standards

Minimum NHSBSP standards must be maintained but Regions may elect to work to tighter standards.

14. New NBSS clinical module

Some units have expressed difficulties using the new clinical module. In particular many units feel it would be helpful if the clinical summary sheet could be amended to use as the referral letter to surgeons copied to the woman's GP. Will Thompson agreed to contact Sarah Sellers and Margot Wheaton.

Action: Will Thompson

15. Radiation dose

See item 5.

16. Use of ultrasound screening in women previously treated for Hodgkin's disease

If a woman qualifies for screening with MRI but MRI is contraindicated (pacemaker etc) then ultrasound may be offered instead. These criteria should also apply to women at high risk due to family history.

17. Imaging implants

One unit in the West Midlands had been routinely screening women with implants using ultrasound instead of mammography and issuing a NHSBSP results letter. All were recalled and offered mammography. In cases where mammography was not possible or declined, it was agreed that ultrasound could be offered according to local protocols but not as part of the NHSBSP. There is no requirement for NHSBSP units to offer ultrasound to women with implants if mammography is not possible or declined.

18. AOB

a) Storing of digital mammographic images

NHSBSP leaflet will not offer an opt out clause although the current information needs augmentation.

b) Digital monitor quality standards

Matthew Wallis volunteered to represent radiologists on this group.

Date of Next Meeting: Wednesday 10th December 2008.