

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 Monday 21 May 2007

Present

Dr R Wilson	Chairman
Dr J Liston	Secretary
Dr J Cooke	South East-East
Dr G Crothers	N. Ireland
Dr K Duncan	Scotland
Dr A Evans	East Midlands
Dr R Given-Wilson	St George’s Training Centre
Dr K Gower Thomas	Wales
Dr E Kutt	South West
Dr J Lavelle	Greater Manchester/Lancs/Cumbria
Dr M Michell	London
Dr P Nisbet	Jersey
Dr A O’Docherty	Dublin
Dr N Perry	Equipment Sub-Group
Dr C Record	South Central
Dr W Thompson	NEYH
Dr M G Wallis	West Midlands
Dr F White	Mersey/Cheshire
Dr R Whitney	Eastern
Dr M Wilson	Manchester Training Centre
Mrs J Patnick	NHSBSP
Ms R Bennett	CSEU

Apologies

Dr E Denton	RCR Breast Group
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1. Minutes of last meeting held on 13 December 2006

The minutes were agreed as an accurate record.

2. Matters arising

PERFORMS – Real Life Study

AE reported that a protocol had been developed. East Midlands QA Reference Centre would co-ordinate the study. A sufficient number of units have volunteered to contribute data. An update of progress will be given by AE at the next meeting.

Action: Andy Evans

Benign Biopsy Audit

RW reported that the national benign biopsy audit had been discussed by the national pathology QA group. The pathologists advise that it is not necessary to surgically remove all mammographic lesions with a B3 core biopsy but that

MDT discussion of individual cases is essential. Written guidelines for pathologists reporting B3 lesions is due to be published later this year.

Breast Screening The Facts

JP advised that complete revision of this leaflet is being undertaken in conjunction with the Cancer Research Campaign Primary Care Evaluation Research Group.

QA Visit Guidelines

JP advised that the publication of these guidelines is delayed as the role of many national NHS organisations including the National Screening Office is currently under review.

It was unanimously agreed that adherence to national guidelines including training requirements, workforce recommendations etc. underpins the success of the national screening programme. If each SHA was allowed to develop regional guidance there was concern that standards would fall and threaten the viability of the national screening programme. RW agreed to write to David Nicholson and Mike Richards.

Action: Robin Wilson

It was acknowledged that adopting the new QA visit Radiology Guidelines would involve more preparation prior to a QA visit. Regional QA Directors may wish to consider using the new guidelines prior to their formal publication.

3. National QA Audit Results 2005/06

Data presented relates to women aged 50 – 64 years. JP advised that these audits would include 50 – 70 year old women in 2008/09 once all units had implemented age extension for a minimum of 3 years.

2005/06 results were circulated by RB (updated revised data attached). It was noted that the recall rate in the prevalent round had increased considerably. This was thought to be due to the recent increase in number of new inexperienced readers. It was suggested if units had high recall rates, arbitration should be used for all recalls not just discordant recalls between first and second readers. QA radiologists should ascertain the reasons for high recall rates at QA visits.

It was again emphasised that a minimum number of 5,000 cases per year should be reported by all readers and that all readers should be actively involved in the assessment process. It was not considered good practice for radiologists in some units to read only arbitration cases as their screen reading skills would be diminished. It was not felt that their reading skills could be maintained by reading only symptomatic films. It was reported that some units undertook triple reporting of films so that each reader read more than 5,000 cases. It was agreed that this was wasteful of resources and units should re-assess their workforce/skill mix if this was happening.

RB reported that overall SDRs were similar to previous years although the prevalent round SDRs were slightly lower.

4. Factors Contributing to Optimal Performance of Individual Screening Units

RB reported that the data collection for radiographer double reading was now 80% complete. Data was still awaited from units in the London region. Mike Michell has written to the units concerned. RB will report the results at the next Big 18.

Action: Rachel Bennett

5. National QA Audits

WT gave an interesting presentation (power point presentation attached) on the state of current practice in the UK regarding axillary node assessment and the use of MRI in treatment planning when the pre-operative core biopsy contained lobular cancer.

It was agreed that ultrasound of the axilla should be undertaken at initial assessment of potential screen detected invasive cancer if surgical management would be influenced by the imaging findings. Published papers indicate that approximately 40% of cases with node positive carcinoma will be identified by the use of axillary ultrasound. It was noted that published data refers mainly to symptomatic cases. There is no data available yet identifying the PPV and NPV of axillary ultrasound in screen detected cancers. The criteria to be used for needing potentially abnormal nodes needs to be revised as more data becomes available. MM agreed to present the results of the London audit at the next Big 18 meeting.

Action: Mike Michell

6. ABS @ BASO Non-operative Diagnosis 05/06

It has been agreed in principle that individual units' data in England should be identified by the screening unit code. Identification of data from units in Wales is still under discussion. In 2005/06 all except seven units met the non-operative diagnosis target for all cancers of >90% and only one unit failed to meet the target for invasive cancers. However 56 units failed to meet a European target of < 20% under staging pre-operatively i.e. < 20% of B5a core biopsies should be invasive at surgery. 50% of women with invasive cancer with a prior B5a core biopsy require a second operation compared to only 14% with a prior B5b core biopsy. MW proposed developing new non-operative diagnosis targets: -

- Relative non-operative diagnosis (invasive) rate
 - % of invasive cancers with a malignant diagnosis pre-operatively
 - minimum standard 85% achievable target 95%.*
- Absolute non-operative diagnosis (invasive) rate
 - % of invasive cancers with an invasive diagnosis pre-operatively
 - minimum standard 85%*
- Non-operative diagnosis (non-invasive) rate
 - % of non-invasive cancers with a diagnosis pre-operatively
 - minimum standard 75%*

Discussion then ensued how cancers diagnosed by cytology alone would fit within the relative non-op diagnosis (invasive) rate.

MGW will discuss his proposal at the National Evaluation Group.

Action: Matthew Wallis

7. CAD Publication

RG-W circulated a paper entitled “Influence of Computer-Aided Detection on Performance of Screening Mammography” published in the New England Journal of Medicine. CAD versus single reading was compared. CAD made recall more likely and increased the biopsy rate but did not significantly improve the cancer detection rate. In summary CAD did not equate with the benefits seen associated with double reading. It was emphasised however that CAD plus full field digital mammography as opposed to conventional film may be different. The CADET 2 study is due to report in 12 – 18 months.

8. 62 Day Target

JP advised that this target for screening cases (date between screen and date of first treatment) is currently being discussed by the DoH for implementation in autumn 2008. The clock might start ticking when a reader records a potentially abnormal result requiring recall for assessment. This may be the date of the first or second read.

9. Cancer Reform Strategy

MM reported that this work had been instigated by the Secretary of State for Health as it is now 6 years since the NHS Cancer Plan was published. The remit of the Cancer Reform Strategy group is to discuss the optimal delivery of cancer services over the next decade taking into account increased incidence, new treatments, patient choice, quality, equality, best use of resources, shift from hospitals to community and prevention /early detection programmes. The breast working group is chaired by Jeremy Hughes who is also Chief Executive of Breakthrough Breast Cancer. Radiology is represented by Mike Michell, Erika Denton and Dorothy Goddard. Topics discussed have included: -

The recommendation that analogue mammography units should be replaced with full field digital mammography units for screening as soon as possible.

Maintenance of a 36 month screening round length.

How to improve uptake in inner city areas.

If sufficient capacity extend the screening age from 47 – 74 years. It is proposed to guarantee that all women will receive their first screen by aged 50 years. AE was concerned that the proposed upper age extension was not evidence based. There are fewer higher grade tumours in older women and the factors around over diagnosis and co-morbidity need to be considered. MM agreed to circulate a letter from J.Cuzick.

Action: Mike Michell

Two-week target for all new referrals in symptomatic clinics.

The recommendation that one-stop symptomatic breast clinics should be imaging led.

National Quality Assurance should be applied to symptomatic services.

The radiologists did not support the proposal to develop community/outreach diagnostic symptomatic clinics.

The need for imaging protocols to be used in symptomatic clinics and strengthening of MDT's.

Harmonisation of screening and symptomatic services -there would be great logistical difficulties in complete physical amalgamation but there was a need to develop closer relationships between screening and symptomatic services. The optimum size for a breast diagnostic unit is under review. This may result in the closure of some small symptomatic units and the division of some of the larger screening services into smaller units. This should result in better alignment of screening and symptomatic services.

10. PACS and CHIMERA Project

This item was deferred to the next meeting.

Action: Erika Denton

11. NHSBSP Training Centres Update

Central funding for the five training centres has been removed. All centres have had to raise attendance fees and cancel courses if insufficient applicants. MM commented that if QA standards are applied to symptomatic services there will be a need for more radiographers to undergo formal training. JP agreed to raise the issue at the National Radiographer QA Group.

Action: Julietta Patnick

JC commented that an MSc is a pre-requisite prior to appointment as a consultant radiographer. MW is concerned that the infrastructure of the training centres will collapse and then 18 months later the DOH will realize that additional training capacity is needed.

12. PERFORMS Gold Standard Reader

The criteria agreed by the group to enable a screening radiologist to act as a gold standard reader was :-

- At least five years experience.
- Reading > 5000 cases per year.
- Participation in all PERFORMS films sets
- Achieving results in the upper quartile.

JL will communicate with Hazel Scott.

Action: Joyce Liston

13. Technically Inadequate Mammograms in Disabled Women

Pilot undertaken in the North West region concluded that if at least 50% of the breast tissue can be included on the films the radiation exposure is justified. It was agreed that a non standard results letter is needed advising that no evidence of breast cancer was seen on the breast tissue imaged but that not all the breast tissue was included on the films.

14. National Guidance for Clinical Recalls

All women with normal mammograms but reporting a significant symptom should be recalled to an assessment clinic. This should be a medical decision. It is not acceptable practice to refer these women to their general practitioner. A list of significant clinical signs and symptoms is included within the NHSBSP publication number 53 “ Information and advice for health professionals in breast screening.”

15. Post Mastectomy Re-constructed Breast

There is no national policy. Imaging of LD flaps may be undertaken according to local protocol.

16. Ruptured Implant Detected on Screening Mammograms

It was agreed that mammographic signs of rupture need not be reported. The purpose of the NHS Breast Screening Programme is to detect breast cancer.

17. Digital Mammography

No money will be available for central procurement of digital equipment for the NHSBSP. The digital implementation group has been disbanded. The implementation of FFD is now part of the remit of the Cancer Reform Strategy.

18. In-situ Interval Cancers

All interval cancers (invasive and DCIS) should be reviewed and classified. Published interval cancer rates however include only invasive interval cancers.

19. Report from other Groups

a) QA Directors

QARCs have suffered a 15% budget cut.

Items discussed included improved linkage with cancer registries, draft guidance on purchasing physics QA testing and the identification of individual units on BASO data.

b) ACBCS Committee

Mike Michell has finished his term on office. Ros Given-Wilson remains a member of this committee but the committee has not met since the last Big 18 meeting.

c) **BASO** (*Report provided by Will Thompson*)

BASO report March 2007

There are plans to produce a national guide to breast cancer, including accurate data from units and patient information. The intention is to act as a 'spoiler' to Dr Foster

New Surgical QA guidelines are in development. They will contain recommendations about imaging and needle sampling of axillary nodes. The attached is from the draft Surgical QA guidelines:

3.2.2 Localisation

Radiological markers must be accurately placed. If ultrasound guided skin marking is used, it should be placed with the patient positioned in the 'operating position' and the depth and size of the lesion clearly recorded.

3.2.3 Specimen Imaging

Confirmation of identification should be made by specimen radiography. Dedicated equipment should be available so that a radiograph can be taken of the specimen and reported to or by the surgeon within 30 minutes. Specimen ultrasound may be useful in those lesions which are not easily visible radiographically. Interpretation of specimen radiographs must be clearly recorded. If this is done by the operating surgeon, the result must be confirmed by the radiologist at the subsequent multidisciplinary team meeting. If the radiologist reports the film at once, no more than 30 minutes should elapse before the reported film is received by the operating surgeon.

4.5 Axillary Node Staging

4.5.1 Invasive cancer

Lymph node status remains the most important prognostic variable for breast cancer outcome, and provides essential information to guide adjuvant treatments. Patients receiving surgery for screen-detected invasive breast cancer should be recommended to have an axillary staging procedure and this recommendation should be documented in their case notes.

Pre-operative assessment of the axilla by ultrasound scan is recommended. Image guided biopsy (FNA or core biopsy) of any abnormal appearing lymph nodes may be carried out to obtain a pre-operative diagnosis of axillary lymph node involvement. Patients with a pre-operative diagnosis of axillary lymph node involvement should usually have definitive treatment by axillary node clearance.

d) National QA Evaluation Group

This group has not met since the last Big 18 meeting.

20. AOB

a) Screening women previously treated for Hodgkin's disease.

The CSEU need to identify the centres and radiologists involved in screening these women. It was suggested that RB contacted the secretary of the RCR Breast Group asking that a request for this information was put on the RCR Breast Group web site. RB to contact Tony Maxwell

Action: Rachel Bennett

b) Payment by results

JP reported that a nationally defined price for screening (versus inviting) a woman might be developed. Setting a correct price is crucial and will include the costs for full field digital imaging and assessment when required assuming some women will require a vacuum assisted core biopsy. A separate price will be developed for screening women with a positive family history aged <50 years.

c) Commissioning

The Carter review of commissioning specialised services is ongoing. JP advised that breast screening should be included within localised groups. There was broad agreement but inclusion within national groups would benefit QA and the call/ recall system.

d) Department of Health Better Regulation

The Department of Health is reviewing the continued relevance of its data collections. JP was asked if all data collected on KC62s and KC63s is still required. The group unanimously agreed that the collection of this data was developed out of the need to deliver a quality service.

e) Marks and Spencer's Private Screening

From April this year M & S subcontracted their screening contract. As part of a cost saving exercise M & S will now pay for the initial screen only and not for assessment.

f) AfC Banding

It was noted that different bands have been awarded for identical job descriptions. This has had a dramatic affect on morale throughout NHSBSP units.

g) RCR Breast Group

MM was asked to justify the inclusion of numbers eg. > 5000 cases/reader /year in the revised training document submitted to the Royal College of Radiologists.

A new speciality “Breast disease management clinicians” has been proposed by the breast clinicians. The breast clinicians believe that consultants in this speciality could lead outpatient breast clinics allowing surgeons and radiologists to undertake other tasks.

h) Re-training for consultant radiologists changing specialty

Secondment training is available at the National Training Centres.

21. Date of Next Meeting

Wednesday 12 December 2007.

29th June 2007.