NABCOP | National Audit of Breast Cancer in Older Patients

@NABCOP_news

ABS Association of Breast Surgery

HQIP Healthcare Quality Improvement Partnership

Royal College of Surgeons of England Advancing Surgical Care

Introduction To The National Audit of Breast Cancer in Older Patients (NABCOP)

Mammary Fold Webinar
Tuesday 19th October 2021

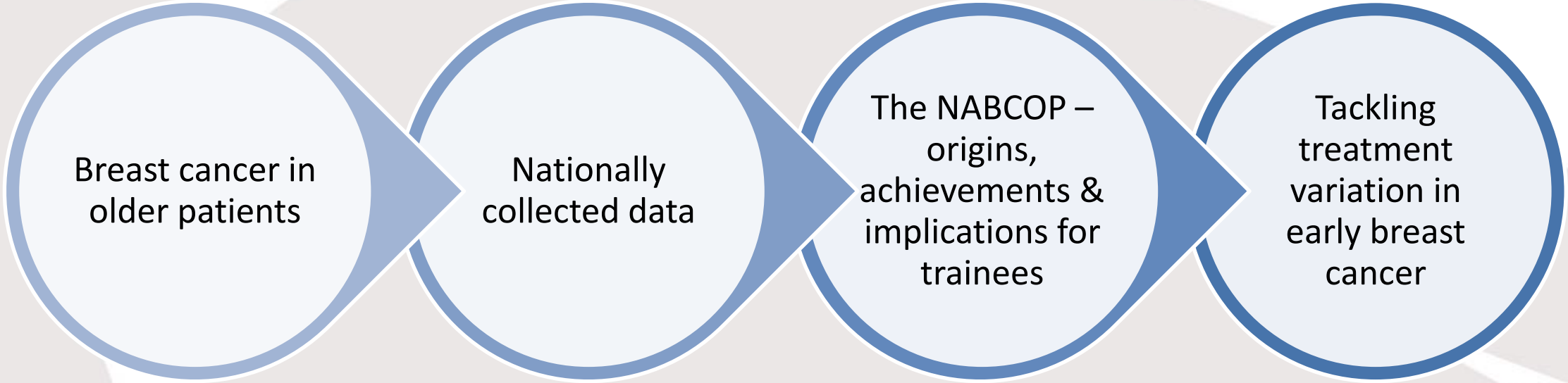
Professor David Dodwell
NABCOP Oncology Clinical lead
Consultant Oncologist, Nuffield Department of Population Health, Oxford

Professor Kieran Horgan
NABCOP Surgical Clinical lead
Consultant Breast Surgeon, St James's University Hospital, Leeds

Dr Katie Miller
NABCOP Clinical Research Fellow
Specialist Registrar in General Surgery, East of England

On behalf of the NABCOP Project Team

Webinar overview

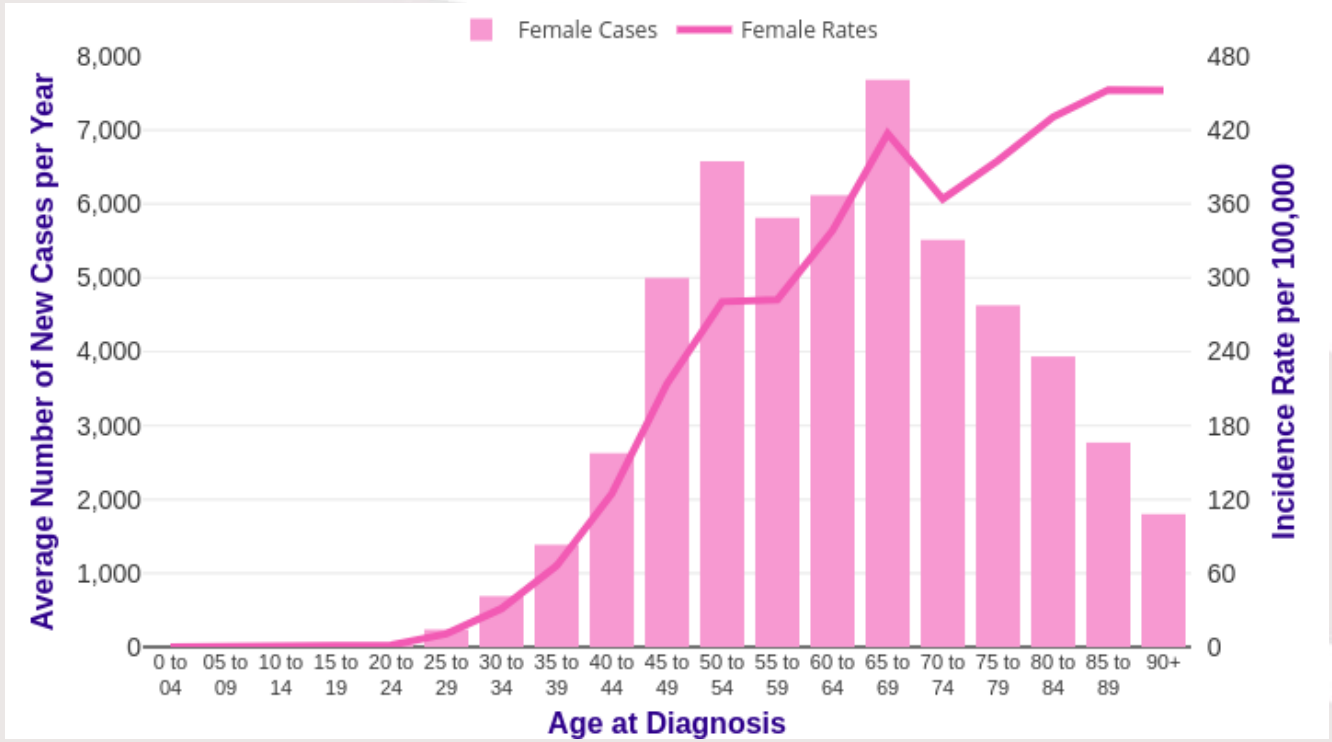


A brief overview – diagnosis and decision-making in older patients with breast cancer

Dr Katie Miller

Breast cancer incidence increases with age

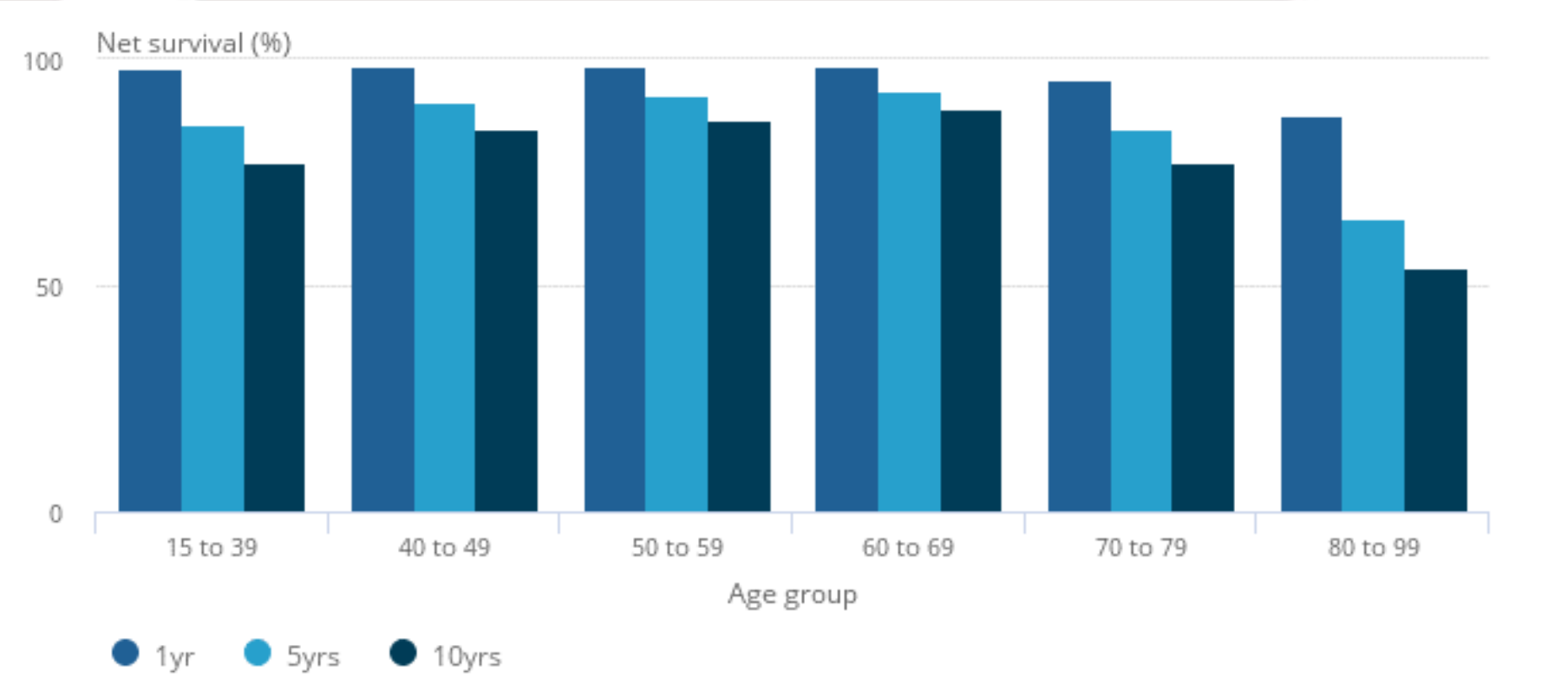
- Around 24% new diagnoses are among those aged 75+ years
- Highest incidence rates are in 85 – 89 age group



Source: Cancer Research UK. Breast cancer incidence (invasive) statistics

Outcomes among older patients

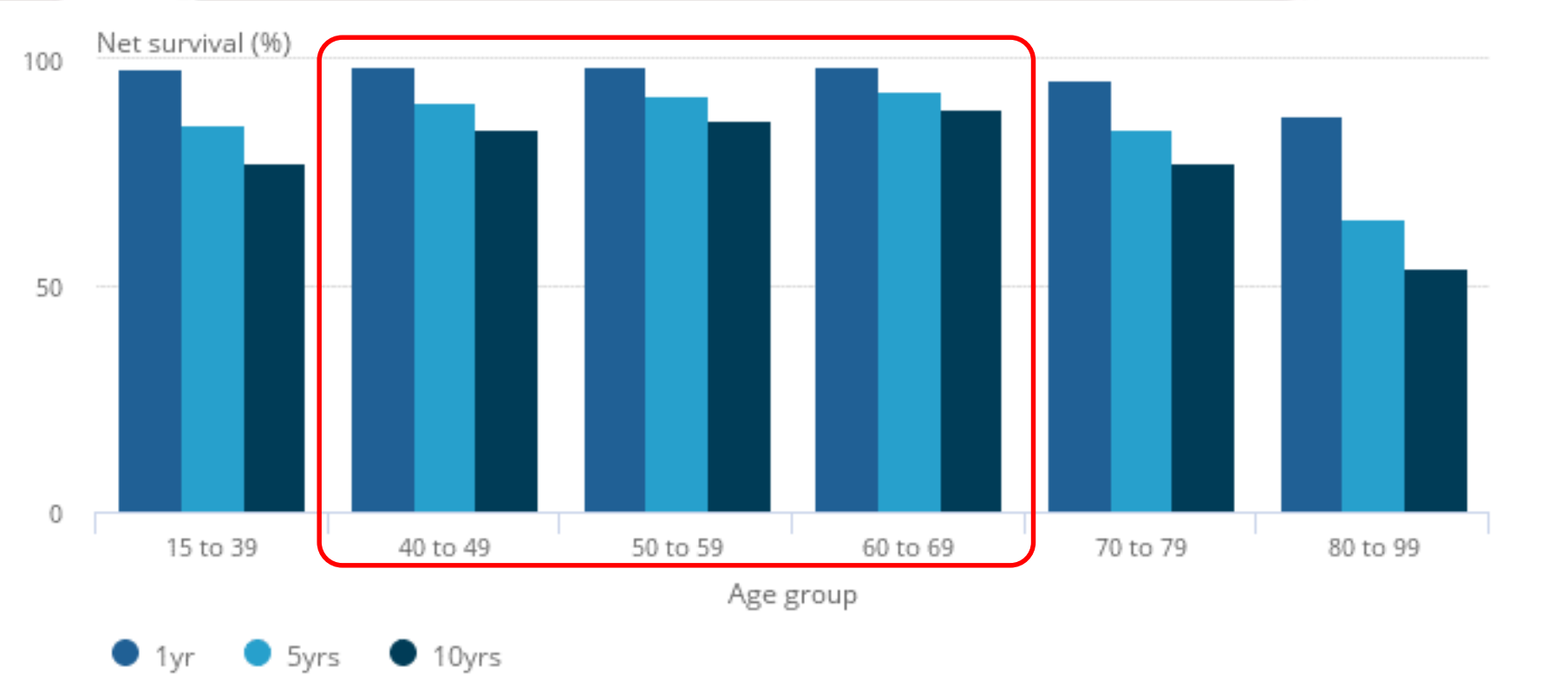
Figure: Age-standardised 1-year, 5-year and 10-year predicted net survival (%) for women with breast cancer in England



Source: Office for National Statistics and London School of Hygiene & Tropical Medicine

Outcomes among older patients

Figure: Age-standardised 1-year, 5-year and 10-year predicted net survival (%) for women with breast cancer in England



Source: Office for National Statistics and London School of Hygiene & Tropical Medicine

Outcomes among older patients

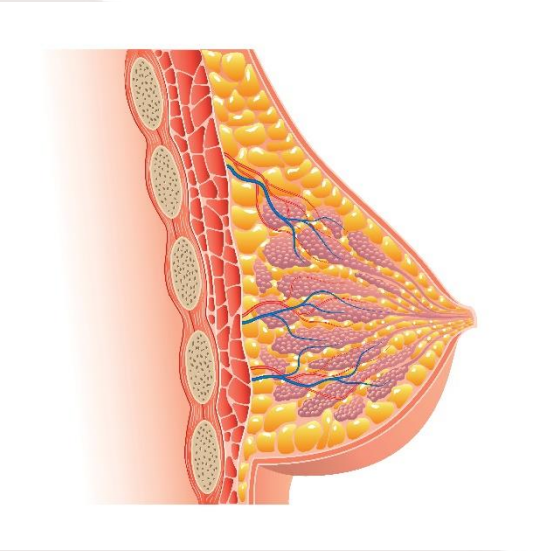
- *Derks et al.* (2018) analysed treatment patterns and survival in patients aged ≥70 in European countries:

Country	5-yr Relative Survival	95% CI
Belgium	97.3	96.2 – 98.1
Ireland	99.4	89.0 – 100.0
The Netherlands	96.0	95.5 – 96.5
England	**93.4**	**93.1 – 93.7**

Source: Derks MGM, Bastiaannet E, Kiderlen M, et al.; EURECCA Breast Cancer Group. Variation in treatment and survival of older patients with non-metastatic breast cancer in five European countries: a population-based cohort study from the EURECCA Breast Cancer Group. Br J Cancer. 2018 Jul;119(1):121-129.

Breast cancer among older patients

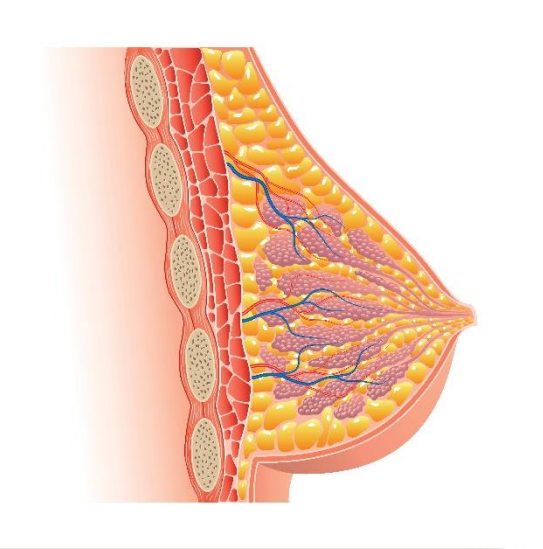
- Larger tumour size
- More advanced stage:
  - Women **75-79 yrs** are **46%** more likely to be diagnosed with stage 3/4 BC compared with women **65-69 yrs**



Source: Lyratzopoulos G, Abel GA, Barbiere JM, Brown CH, Rous BA, Greenberg DC. Variation in advanced stage at diagnosis of lung and female breast cancer in an English region 2006-2009. Br J Cancer. 2012;106(6):1068-75.

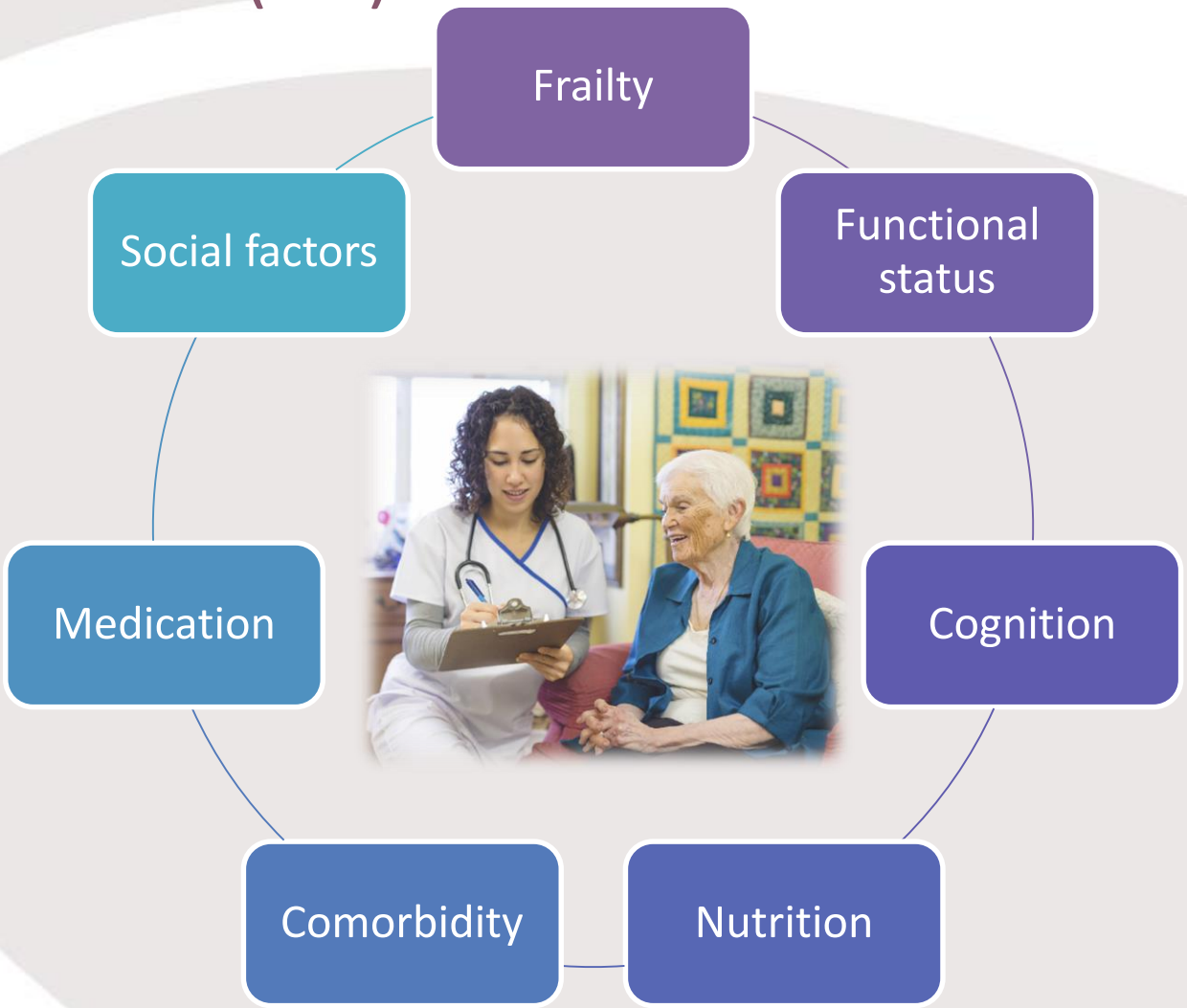
Breast cancer among older patients

- Larger tumour size
- More advanced stage:
  - Women **75-79 yrs** are **46%** more likely to be diagnosed with stage 3/4 BC compared with women **65-69 yrs**
- NABCOP data – older patients (>70 years) may have similar grade and molecular markers compared to women aged 50 – 69 years



Source: National Audit of Breast Cancer in Older Patients (NABCOP) 2020 Annual Report.

Geriatric assessment (GA)



Clinical guidelines

International Society of Geriatric Oncology (SIOG)

*"Nonetheless, **functional age** (i.e. not chronological age) and **potential underlying frailty** should contribute to decision making about treatment."*

National Institute for Health and Care Excellence (NICE)

*"Treat people with invasive breast cancer, **irrespective of age**, with surgery and appropriate systemic therapy…unless significant comorbidity precludes surgery."*

European Society for Medical Oncology (EMSO)

*"'Younger' patients should not be overtreated because they are 'young', just as **'older' patients should not be undertreated** solely based on their calendar age."*

The balance between under and over treatment

Tang et al. reviewed post-operative mortality rates among women who received breast surgery who lived in a nursing home:

- 30-day mortality **3.2%**
- 1-yr mortality **30.9%** (among those alive at 1-yr)
- **58.3%** experienced functional decline at 1-yr

Source: Tang V, Zhao S, Boscardin J, Sudore R, Covinsky K, Walter LC, et al. Functional Status and Survival After Breast Cancer Surgery in Nursing Home Residents. JAMA Surg. 2018;153(12):1090-6.

Principles of decision-making among older oncology patients

Figure adapted from DuMontier et al. Decision Making in Older Adults With Cancer. Journal of Clinical Oncology 2021 39:19, 2164-2174.

Nationally collected data – strengths and limitations

David Dodwell

National Data Sources

- Cancer Outcomes and Services Dataset (COSD)
- Hospital Episode Statistics (In-patient, out-patient and A&E) – e.g. surgery, co-morbidity, routes to diagnosis, etc.)
- Treatments – SACT, RTDS
- Cancer Waiting Times
- National Audits (Prostate, lung and new breast audit fully integrated with NCRAS)
- Primary care prescription data
- Diagnostic Imaging Dataset
- Molecular Diagnostics (direct from molecular biology labs)
- National Cancer Patient Experience Survey
- Limited PROMs data

NABCOP data sources

Patients diagnosed in England

- National cancer registration dataset
- Rapid Cancer Registration Dataset
- The Cancer Outcomes and Service Dataset (COSD)
- Hospital Episode Statistics dataset (HES)
- Systemic Anti-Cancer Therapy dataset (SACT)
- National Radiotherapy Dataset (RTDS)
- Office for National Statistics (ONS) mortality data

Patients diagnosed in Wales

- Data Analysis Wizard (DAW) extract and Welsh Breast Cancer Clinical Audit (WBCCA) extract from the Canisc patient record system;
- Patient Episode Database for Wales (PEDW)
- Welsh radiotherapy dataset
- Office for National Statistics (ONS) mortality data

The NABCOP – origins, achievements, and implications for trainees

Professor Kieran Horgan
Dr Katie Miller

Setting and upholding standards

- ABS instrumental in setting of standards for management of breast cancer in the UK

- Standards will only fulfil their potential to optimise care if attainment is measured

Origins of the NABCOP

- National audits
  - Initial submission by ABS 2011 – other tumour sites deemed to require scrutiny more urgently
  - Resubmitted in 2014 to HQIP (Healthcare Quality Improvement Partnership) to claim final national audit slot of 11 across medicine
  - Initial proposal – to audit all breast cancer
  - Large 'Noah's Ark' open review panel of the submission – "too broad" & "should be more far reaching"

Origins of the NABCOP

- 2014 –
  - All interested parties canvassed to identify the area of UK breast cancer care where it was judged to be suboptimal, and if rectified offered the largest benefit for the greatest number of patients
  - **Care of the older patients was the most frequent response by a wide margin**

Origins of the NABCOP

- Who is “old”?
- Audit designed to study patients aged **70+ years**…

  …but agreed to include women **50-69 years** as a comparator group thereby auditing >70% of all patients with breast cancer in England/Wales
- Joint collaboration between ABS and Clinical Effectiveness Unit of RCSEng (home to multiple national audits)
- What does good care look like?
- Work with pre-exciting national datasets – no extra demand on units
- Multi-professional Clinical Steering Group – first met 28th September 2016

Key achievements & findings

- Measurement of patient fitness
- Quality improvement resources
- Pilot projects
- Key findings

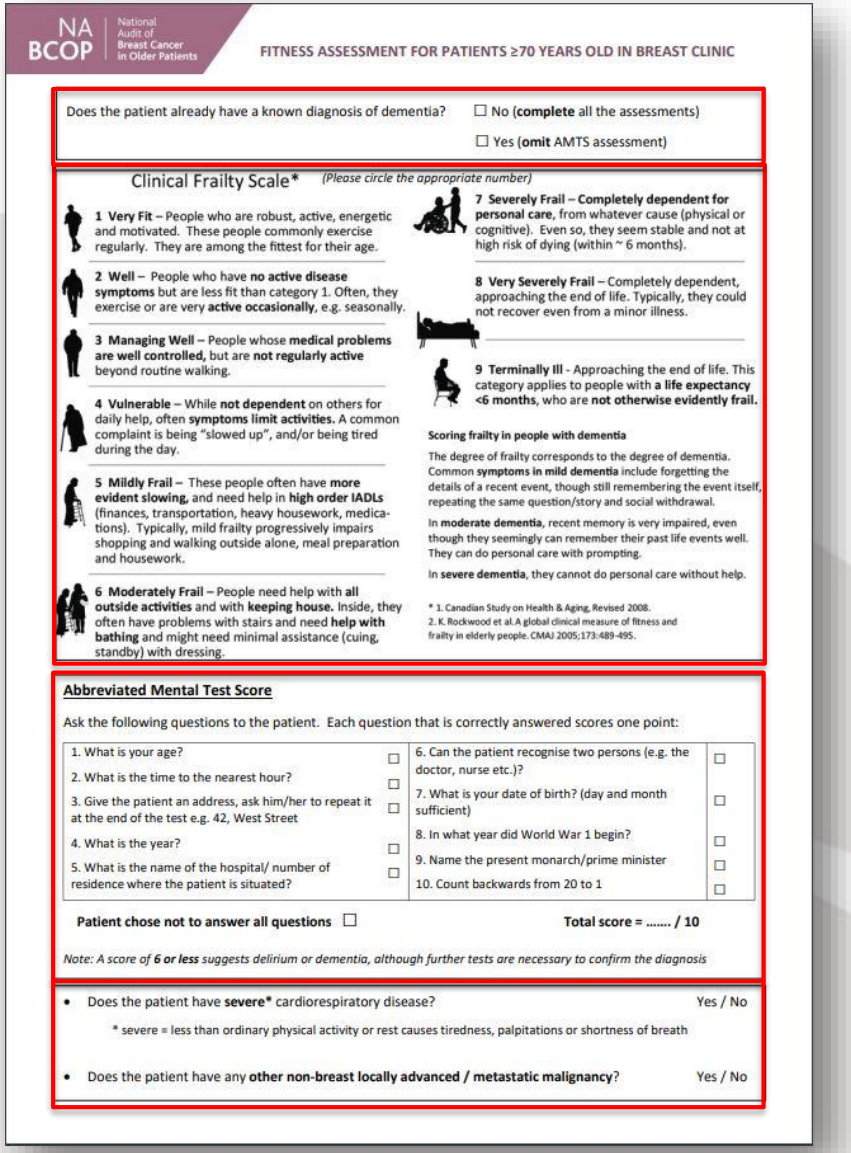
Key achievements & findings

- Measurement of patient fitness
- Quality improvement resources
- Pilot projects
- Key findings

Patient fitness

- NABCOP fitness assessment form

- COSD Version 9
  - Breast cancer specific items on patient fitness
  - Enable patient-level frailty information to be collected on women aged 50+ yrs



NA BCOP National Audit of Breast Cancer in Older Patients

FITNESS ASSESSMENT FOR PATIENTS ≥70 YEARS OLD IN BREAST CLINIC

Does the patient already have a known diagnosis of dementia? ☐ No (**complete** all the assessments) ☐ Yes (**omit** AMTS assessment)

Clinical Frailty Scale* *(Please circle the appropriate number)*

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 Managing Well – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

Abbreviated Mental Test Score

Ask the following questions to the patient. Each question that is correctly answered scores one point:

1. What is your age?	☐	6. Can the patient recognise two persons (e.g. the doctor, nurse etc.)?	☐
2. What is the time to the nearest hour?	☐	7. What is your date of birth? (day and month sufficient)	☐
3. Give the patient an address, ask him/her to repeat it at the end of the test e.g. 42, West Street	☐	8. In what year did World War 1 begin?	☐
4. What is the year?	☐	9. Name the present monarch/prime minister	☐
5. What is the name of the hospital/ number of residence where the patient is situated?	☐	10. Count backwards from 20 to 1	☐

Patient chose not to answer all questions ☐ **Total score = ... / 10**

*Note: A score of **6 or less** suggests delirium or dementia, although further tests are necessary to confirm the diagnosis*

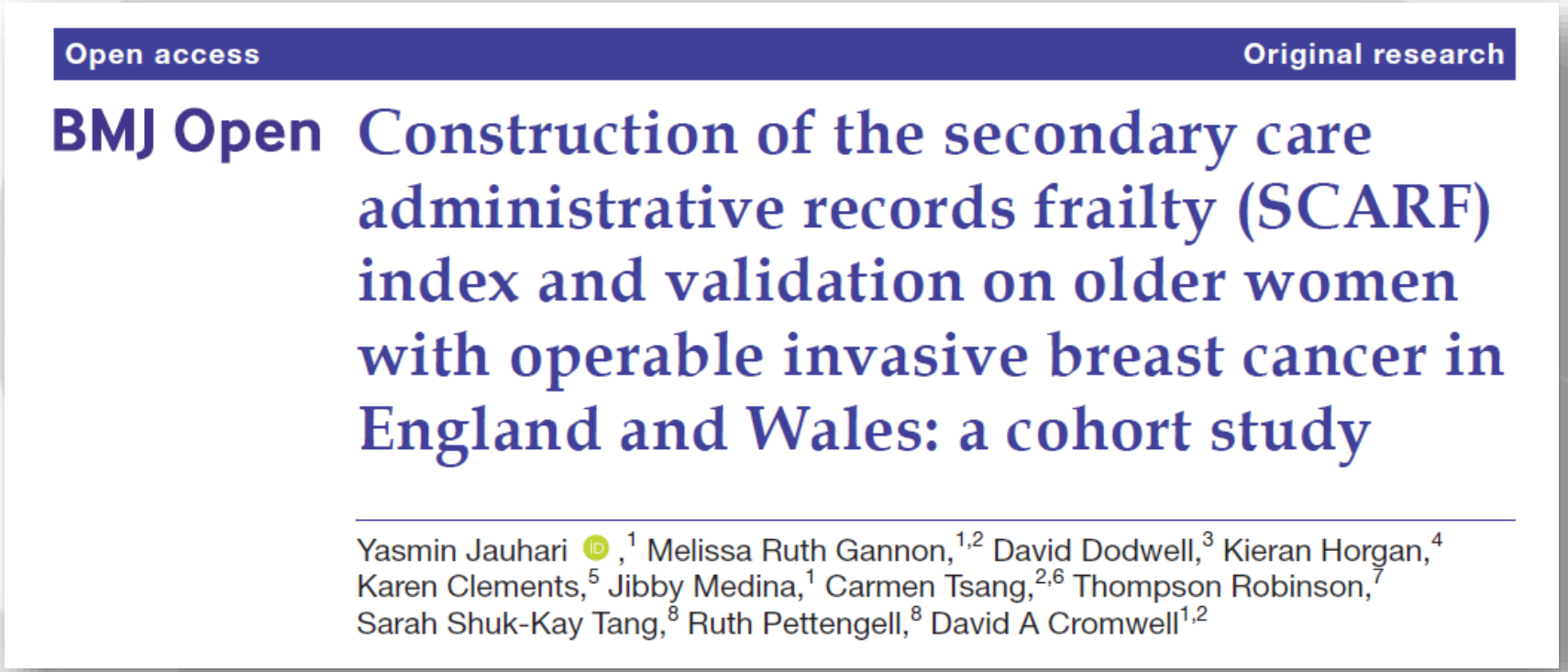
- Does the patient have **severe*** cardiorespiratory disease? Yes / No

  * severe = less than ordinary physical activity or rest causes tiredness, palpitations or shortness of breath

- Does the patient have any **other non-breast locally advanced / metastatic malignancy**? Yes / No

Patient fitness

- Secondary Care Administrative Records Frailty (SCARF) index


Open access Original research

BMJ Open

Construction of the secondary care administrative records frailty (SCARF) index and validation on older women with operable invasive breast cancer in England and Wales: a cohort study

Yasmin Jauhari ,[1] Melissa Ruth Gannon,[1,2] David Dodwell,[3] Kieran Horgan,[4] Karen Clements,[5] Jibby Medina,[1] Carmen Tsang,[2,6] Thompson Robinson,[7] Sarah Shuk-Kay Tang,[8] Ruth Pettengell,[8] David A Cromwell[1,2]

Key achievements & findings

- Measurement of patient fitness
- Quality improvement resources
- Pilot projects
- Key findings

NABCOP | National Audit of Breast Cancer in Older Patients

@NABCOP_news

ABS Association of Breast Surgery

HQIP Healthcare Quality Improvement Partnership

Royal College of Surgeons of England Advancing Surgical Care

Quality improvement resources

- Annual Report Supplementary materials
  - Data viewer
  - Local action plan
- Guide for older patients with BC
- Patient level dataset
  - Key data items

A guide to asking important questions along the breast cancer pathway: Of particular relevance to women aged 70+ diagnosed with breast cancer

- Researchers have found that the treatment older patients with breast cancer of younger patients.
- The National Audit of Breast Cancer in Older Patients (NABCOP) was set up to consistent with recommended practice and to identify where there are differ
- If you are a **woman aged 70+** diagnosed with breast cancer, we hope this gui **use it with your clinical nurse specialist (CNS)** to talk about some important t

The picture to the right shows the sequence of steps in a typical breast cancer pathway, from diagnosis to treatment, in English and Welsh hospitals.

Over the page you will find information on each of these steps in the pathway along with some prompts for questions you may find useful to ask as a woman aged 70+.

MDT meeting — To discuss treatment options

The exact breast cancer treatment(s) and order in which they are given will be tailored to each individual patient and their needs.

Diagnosis of

Breast cancer tre

Surgery

Surgery includes having an operation to the breast and possibl removing some or all lymph nodes from the armpit (axilla).

Follow-up

Follow-up can be in the of regular mammogram clinic visits (or both), to sure you are well after finishing your treatment

Please note: This pathway has been simplified for general use by all patients and not all pat Your individual treatment plan will be discussed with you by the breast cancer

Below you can write down any thoughts or questions you might have, a

This guide has been developed in collaboration with members of:

BREAST CANCER NOW

Diagnosis of breast cancer

When your breast cancer was diagnosed, you will have had a breast examination, imaging of your breasts, and a tissue sample or 'biopsy' taken.

The results from these investigations will be reviewed in a multidisciplinary team (MDT) meeting where specialists will discuss what treatments are available to treat your specific breast cancer.

Questions to ask your breast care team:
- What size is my breast cancer, according to my test results?
- Has my cancer spread e.g. to the armpit nodes?
- How is my general health & fitness for treatment assessed?
- Is surgery an option for my breast cancer?

The items below should be recorded about your breast cancer. **The NABCOP found these are less likely to be recorded in older women.** Ask your breast cancer team if these have been recorded for you:
- ✓ **Estrogen/progesterone receptor status**
- ✓ **HER2 status** (if you have invasive breast cancer)
- ✓ **Nodal stage** (spread to armpit lymph nodes)
- ✓ **Tumour grade**
- ✓ **Tumour size**

Supporting you through treatment (& decision making)

Your breast care team are there to help and support you through your diagnosis and treatment. The questions to the right may help you to work through any concerns you may have before or during treatment.

Questions to ask your breast care team:
- How will treatment affect my day to day activities?
- Are there any clinical trials which I could consider?
- What support is available for me if I am a carer for others?
- Who can I talk to for help with my mental health?
- Is there any financial support available for me?

Surgery

This will involve an operation to the breast and possibly to the axilla (armpit). The NABCOP has found that fewer older women have surgery for breast cancer compared with younger women, and so it is important to ask your breast surgeon whether you are a candidate for surgical treatment. If surgery is not an option, you may be offered hormonal (endocrine) therapy as an alternative.

Questions to ask your breast surgeon:
- How can I prepare myself physically & mentally for surgery?
- What are the pros & cons of having a lumpectomy over a mastectomy?
- Is breast reconstruction an option for me?
- How does recovery from this surgery compare to joint replacement surgery?
- What can I do to help myself recover from surgery?
- What are the risks of needing another operation?

(Neo) Adjuvant therapy

Adjuvant therapies are additional treatments you may be offered for breast cancer. Some might be offered *before* your surgery and are called 'neoadjuvant therapy'. You should discuss with your breast cancer team if this is an option for you.

Questions to ask your breast oncologist:
- What therapy is best for my breast cancer?
- Am I a candidate for chemotherapy, radiotherapy or any other treatments?
- Will the treatment be in the form of tablets, injections or...?
- When will my therapy start and how long will it last?
- What are the side effects of the therapy?
- How will I know if the treatment is working?

Follow-up

Your breast unit will organise appropriate follow-up for you. This may be clinic appointments, telephone consultations or an open access service. The type of follow-up appointments and how often they are organised will depend on your hospital and what treatment(s) you received.
Women aged 71 and over can still ask for breast screening after the 5 years of annual follow-up mammograms – if this applies to you, ask your breast unit or GP for more information*.

*Note – due to the COVID-19 pandemic, self-referral for breast screening for women aged 71+ is not available at the time of publication (September 2020). Please consult your GP if you have concerns about unusual breast changes.

Questions to ask your breast care team:
- How often will you see me to check I'm ok?
- Where can I find support on adapting to life after breast cancer?
- What are the signs I should look out for of my breast cancer returning?

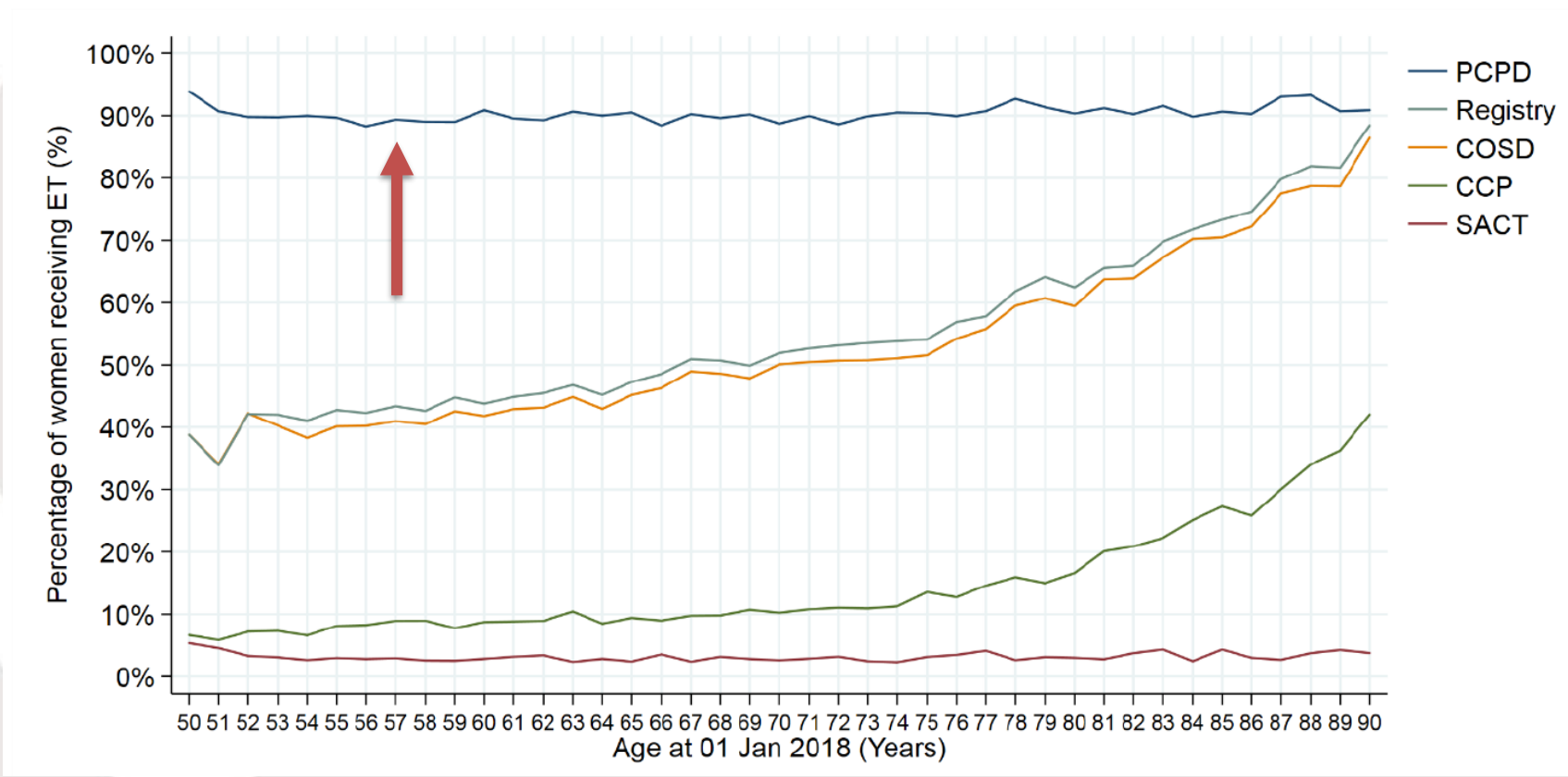
Find out more
- If you would like to know more about the NABCOP or for links to general information about breast cancer, please visit our FAQs page: https://www.nabcop.org.uk/about/faq/public/
- For copies of our Public and Patient reports please visit https://www.nabcop.org.uk/reports/

Key achievements & findings

- Measurement of patient fitness
- Quality improvement resources
- Pilot projects
- Key findings

Pilot projects – Endocrine therapy prescriptions

Figure: Use of ET identified within PCPD (2018) prescriptions compared with routine secondary care sources, by age

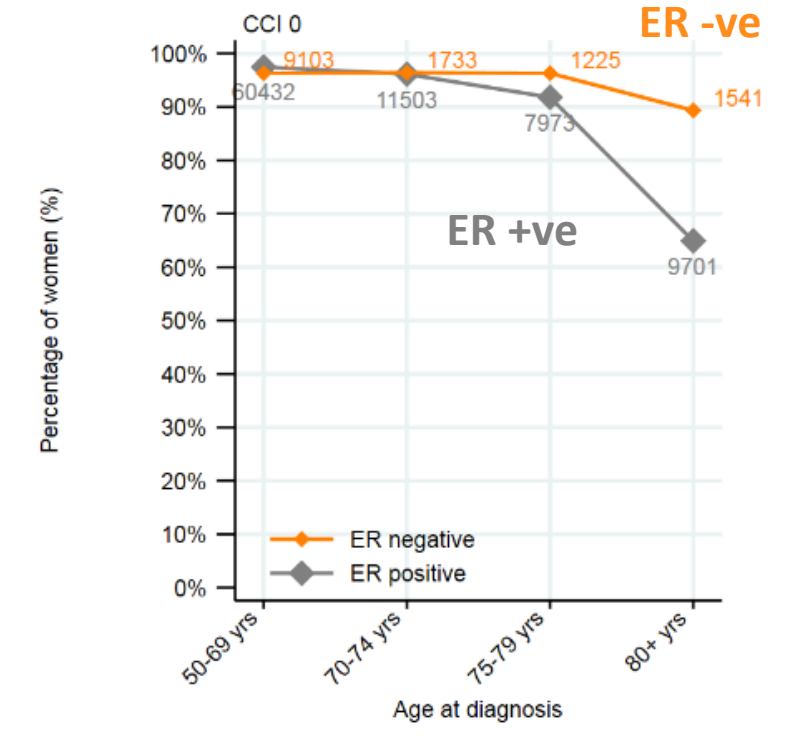


Key achievements & findings

- Measurement of patient fitness
- Quality improvement resources
- Pilot projects
- Key findings

Impact of fitness on likelihood of receiving surgery for EIBC, by age and ER status

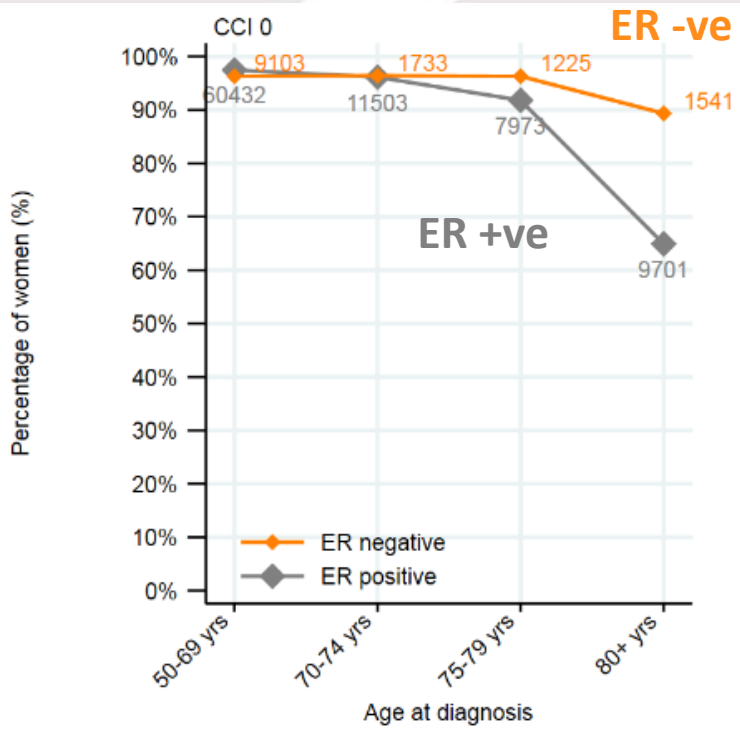
CCI 0



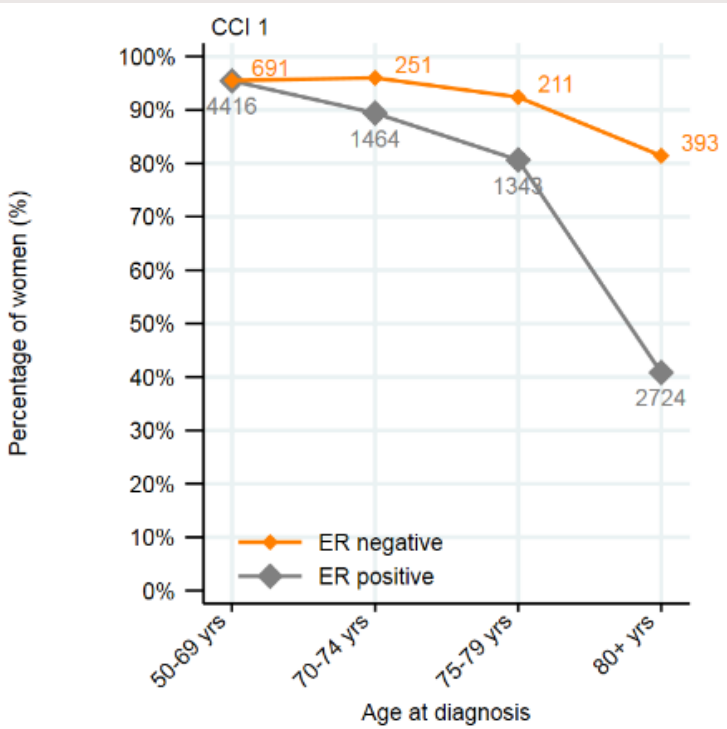
Source: National Audit of Breast Cancer in Older Patients (NABCOP) 2020 Annual Report, Chapter 8 Figure 8.2.

Impact of fitness on likelihood of receiving surgery for EIBC, by age and ER status

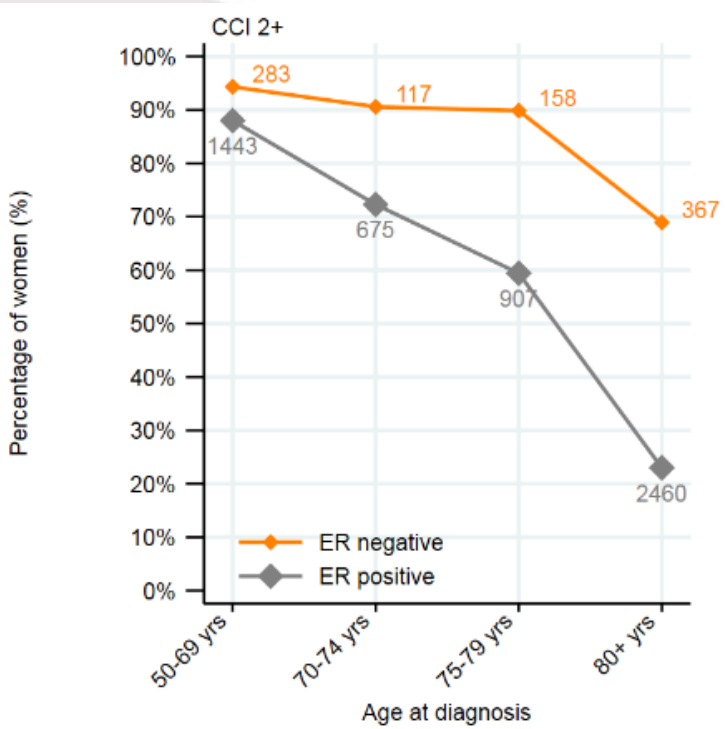
CCI 0



CCI 1

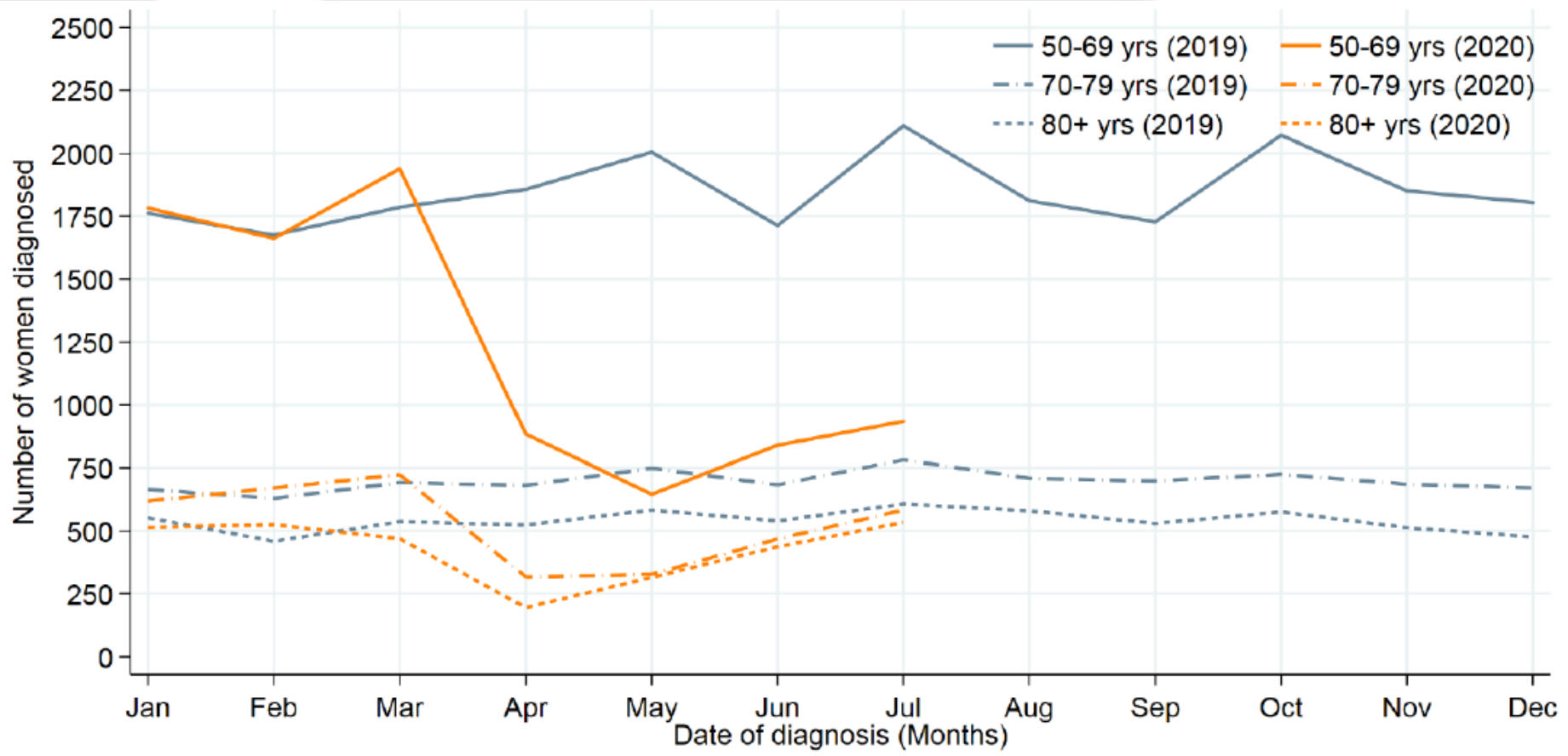


CCI 2+



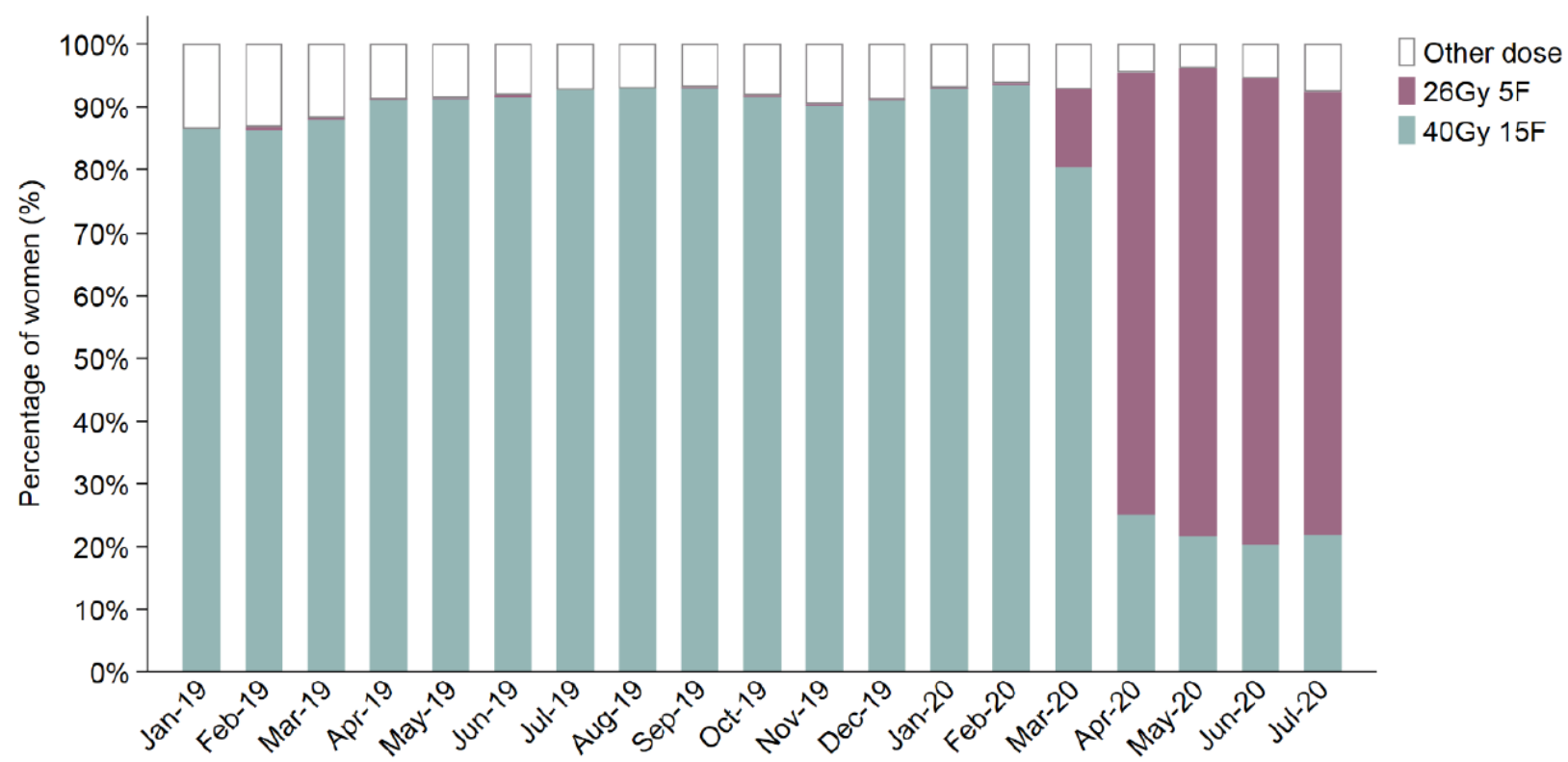
Source: National Audit of Breast Cancer in Older Patients (NABCOP) 2020 Annual Report, Chapter 8 Figure 8.2.

Number of women diagnosed with breast cancer in England, by year of diagnosis and age



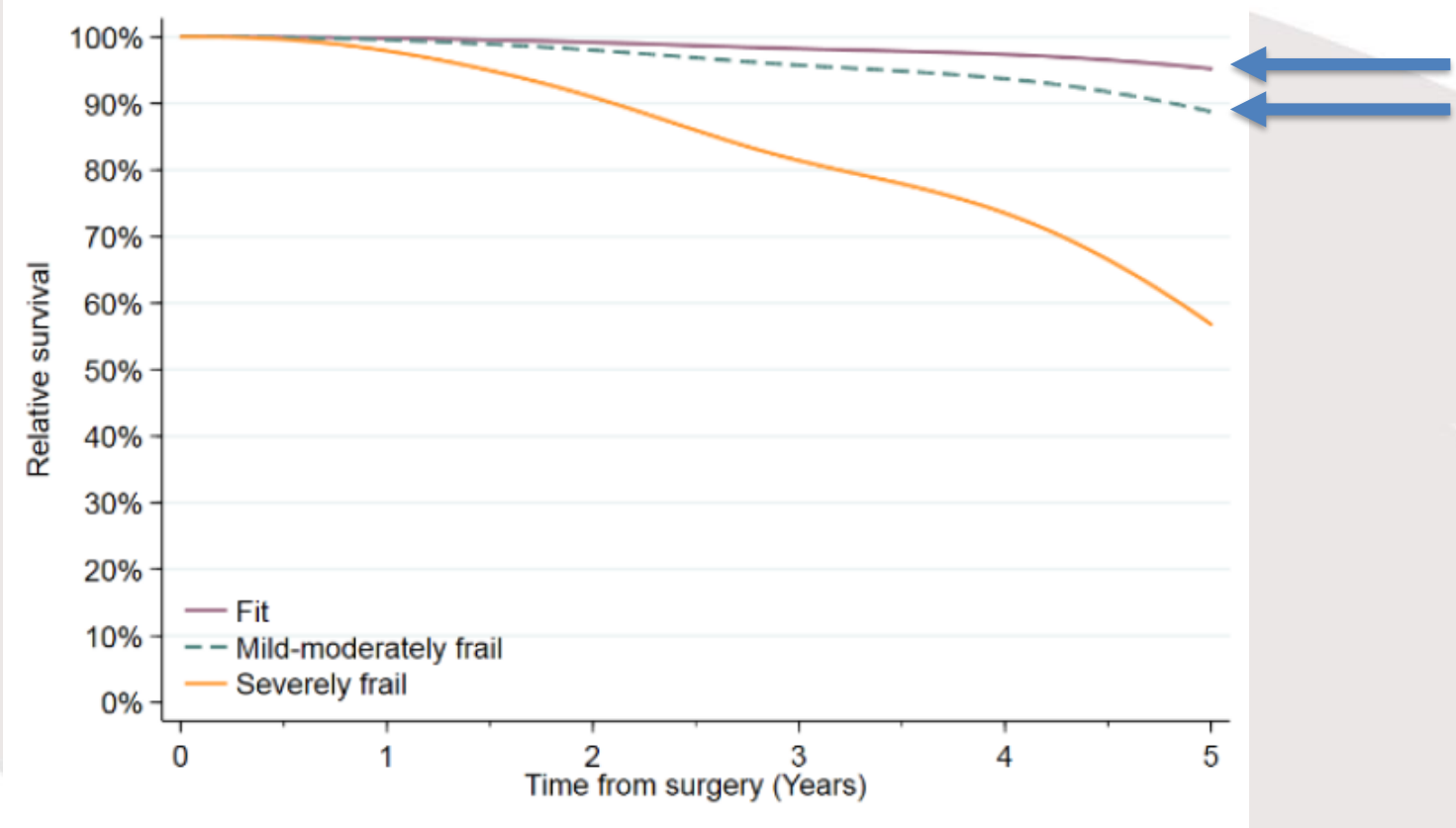
Source: National Audit of Breast Cancer in Older Patients (NABCOP) 2021 Annual Report, Chapter 3 Figure 3.3.

Radiotherapy (RT) dose among women starting RT for operable non-invasive or early invasive BC, by start date of RT



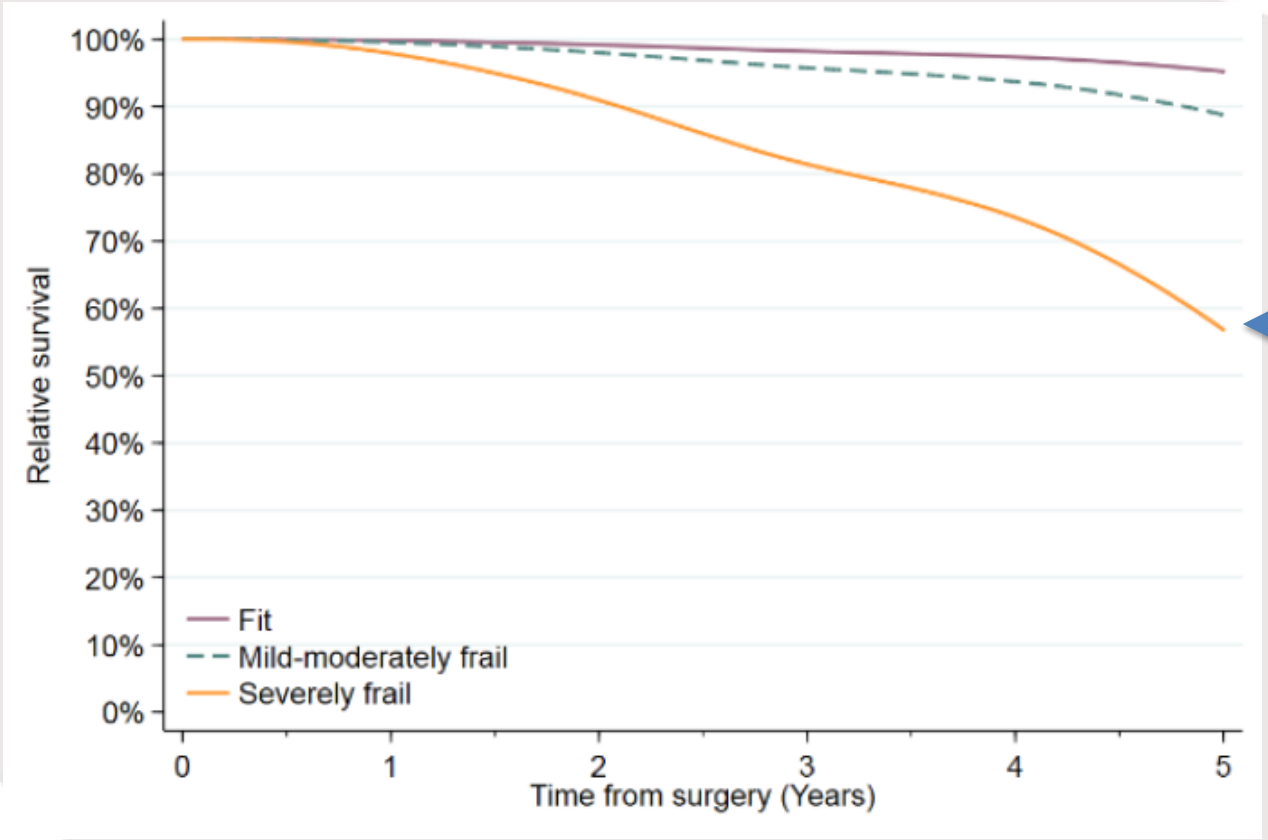
Source: National Audit of Breast Cancer in Older Patients (NABCOP) 2021 Annual Report, Chapter 3 Figure 3.15.

Relative survival of women diagnosed with early invasive breast cancer who received surgery, by SCARF (frailty) index



Source: National Audit of Breast Cancer in Older Patients (NABCOP) 2021 Annual Report, Chapter 5 Figure 5.6.

Relative survival of women diagnosed with early invasive breast cancer who received surgery, by SCARF (frailty) index



Source: National Audit of Breast Cancer in Older Patients (NABCOP) 2021 Annual Report, Chapter 5 Figure 5.6.

The NABCOP – implications for trainees

How are NABCOP products useful for trainees?

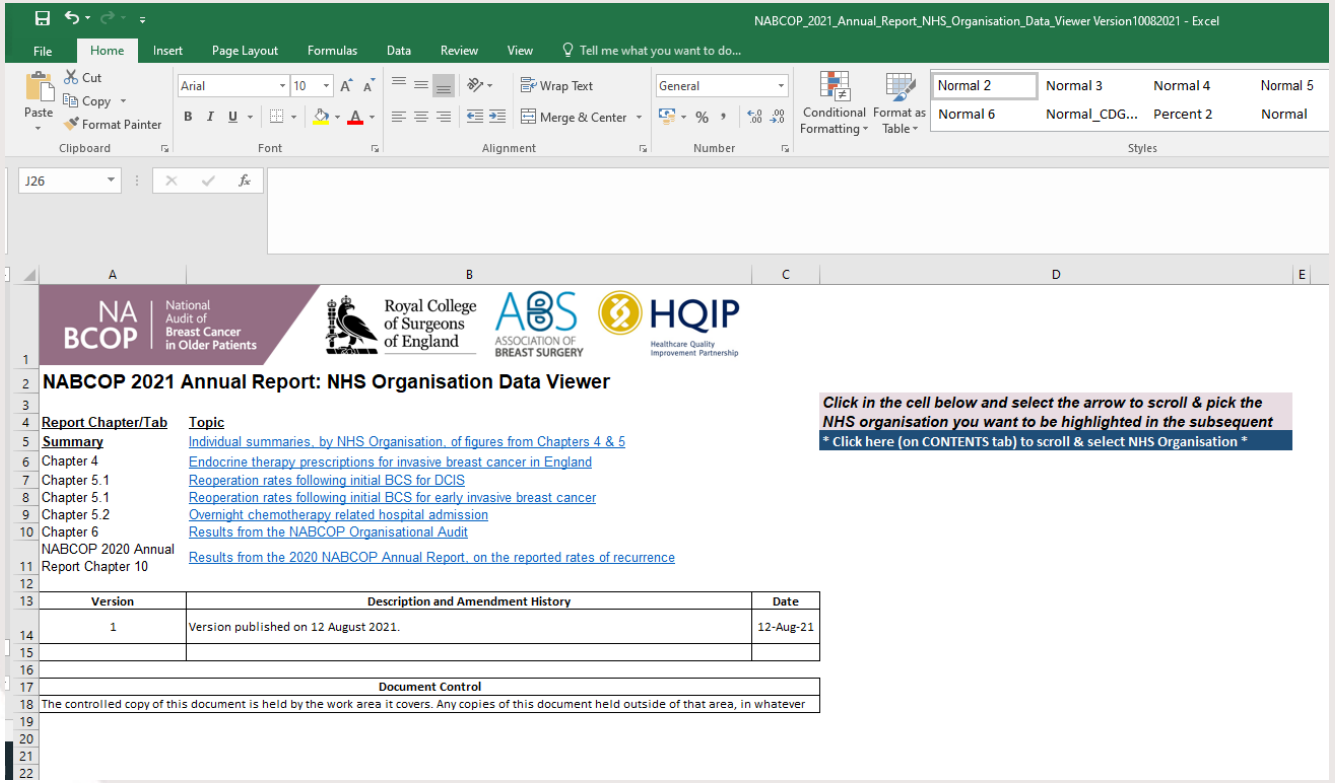
- Initial part of the QI process (data collection) has been performed

- Help to fulfil curriculum requirement to perform one audit/QI project per year

NABCOP QI resources – data viewer

Organisation data viewer

https://www.nabcop.org.uk/resources/nabcop-2021-annual-report-supplementary-materials/

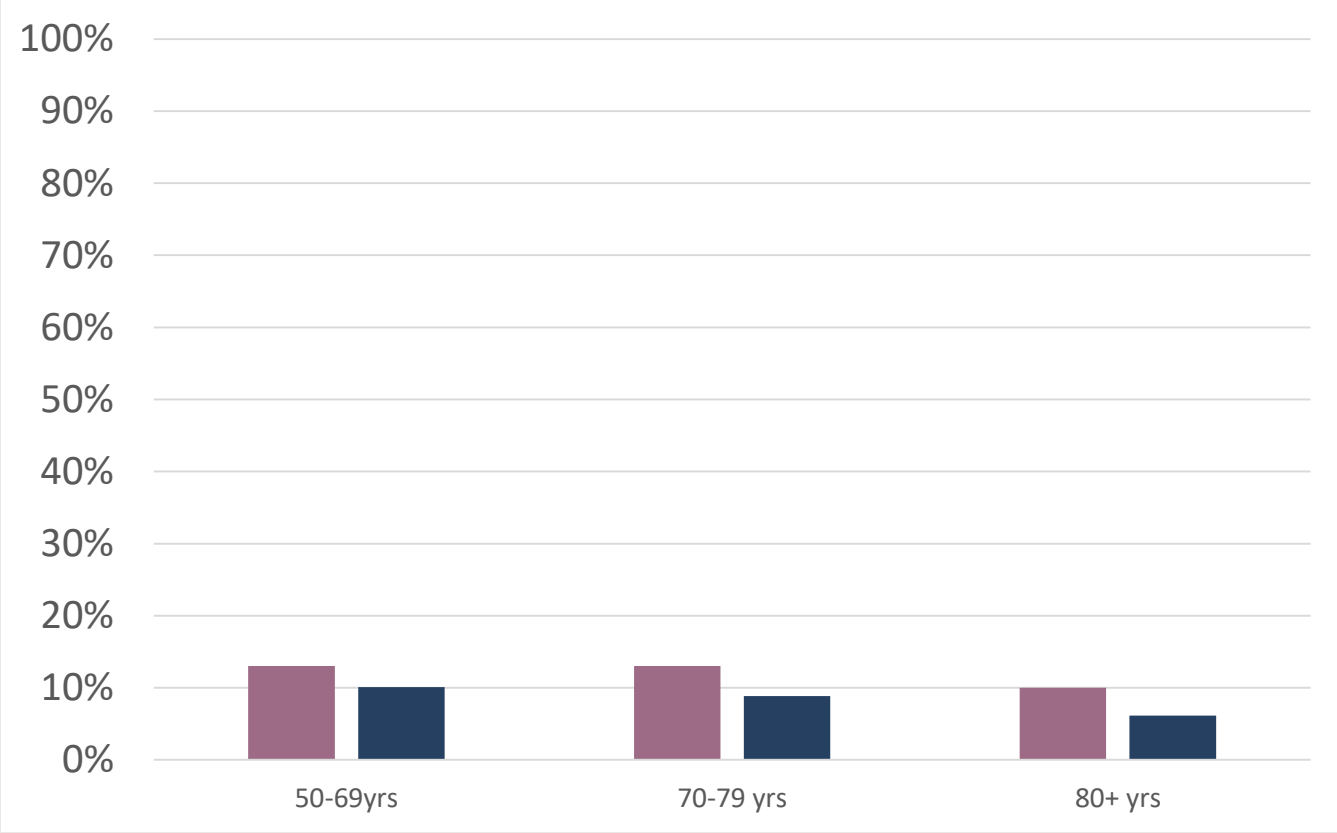


NABCOP QI resources – data viewer

Resources on minimising re-operation rates:

- Getting It Right First Time (GIRFT) Report
- American Society of Breast Surgeons 'Toolbox' to Reduce Lumpectomy Reoperations

Re-operation rates for women with EIBC



NABCOP QI resources – action plan

Local action plan

https://www.nabcop.org.uk/resources/nabcop-2021-annual-report-supplementary-materials/

Local Action Plan for taking on NABCOP 2021 Annual Report Recommendations	
The provider should complete the following details to allow for ease of review:	
Audit title & aim:	The National Audit of Breast Cancer in Older Patients (NABCOP). Evaluates the processes of care and outcomes for women aged 70+ years with a diagnosis of breast cancer, compared with those among women diagnosed with breast cancer aged 50-69 years.
NHS organisation:	
Audit lead:	
Action plan lead:	

When making your action plan, make sure to keep the objectives SMART – **S**pecific, **M**easurable, **A**ssignable, **R**ealistic, **T**ime-related.

Note: Organisation-level data relating to each recommendation listed below can be found in the '**NABCOP Annual Report 2021 NHS Organisation Data Viewer**' here: https://www.nabcop.org.uk/resources/nabcop-2021-annual-report-supplementary-materials/

Key 1 (for the action status)
1: Awaiting plan of action
2: Action in progress
3: Action fully implemented
4: No plan to action recommendations (state reasons)
5: Other (provide information)

Key 2 (for the action priority)
HIGH: requires urgent action, and local audit
MEDIUM: requires prompt action, and consider local audit
LOW: requires no immediate action or local audit

No.	Recommendation (*Guidance available – Full detail on final page*) [Related report section]	Action required? (*Yes/No; state intended action OR reason for no action*)	Action activities: Responsible individual(s)	Agreed deadline	Status (*see Key 1*)	Priority (*see Key 2*)
Rec 1	**Recording of routine data items** Ensure information on endocrine therapy treatment started in secondary care is recorded within routine data submissions to NCRAS (COSD) and WCN databases. [Chapter 4]	*Suggested actions:* *Review the data completeness of this information for your organisation. NHS trusts in England can access CancerStats[1] to see their data uploads in real time.*				

[1] https://www.nabcop.org.uk/resources/cancerstats-area/

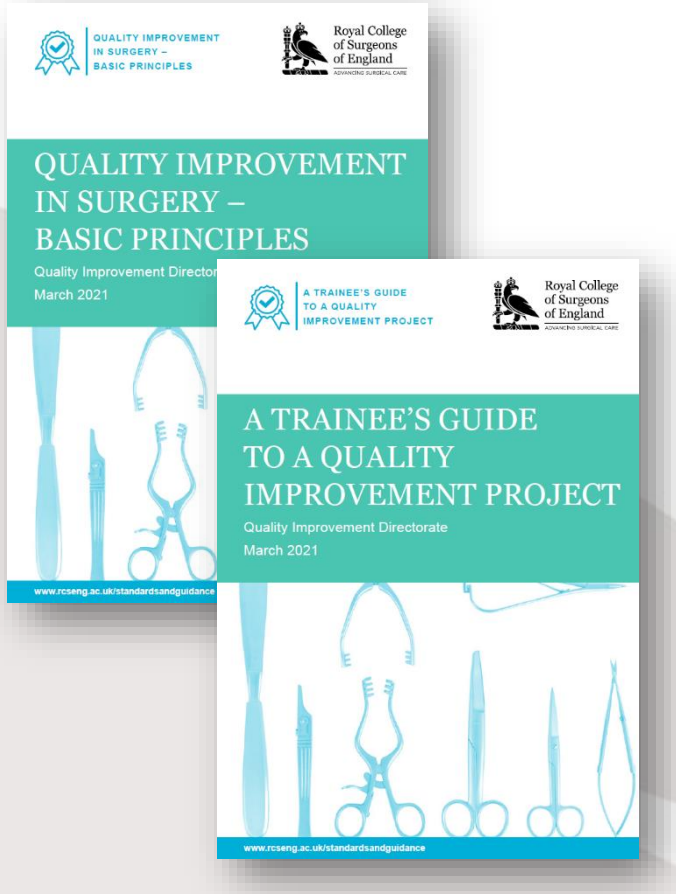
Page 1 of 5 NABCOP Local Action Plan 2021

Additional QI resources

- NABCOP website

- Royal College of Surgeons of England QI guides:
  - Quality Improvement in Surgery – Basic Principles
  - A Trainees Guide to a Quality Improvement Project

- Healthcare Quality Improvement Partnership
  - E-learning: QI for healthcare professionals



We want to hear from you!

- We welcome suggestions on what trainee specific QI products we could offer

- To stay updated with the latest NABCOP news:

www.nabcop.org.uk
nabcop@rcseng.ac.uk
@NABCOP_news

Tackling treatment variation in early breast cancer

Professor David Dodwell

Breast cancer national audits

Year	Provenance	Name	Focus
<2000	Audit	NHSBSP/ABS	Screen-detected cancer
2002	Audit	Sloane	Screen-detected DCIS
2004	Audit	BCCOM	Symptomatic cancer
2008	Audit	Mx. & Reconstruction	Reconstructive surgery
2012	Audit	Sloane	Risk lesions and atypia
2014	Audit	iBRA/ iBRA2	Reconstructive surgery
2016	Audit	NABCOP	Older patients
2017	Commissioning	GIRFT	Breast surgery

Mastectomy rate variability

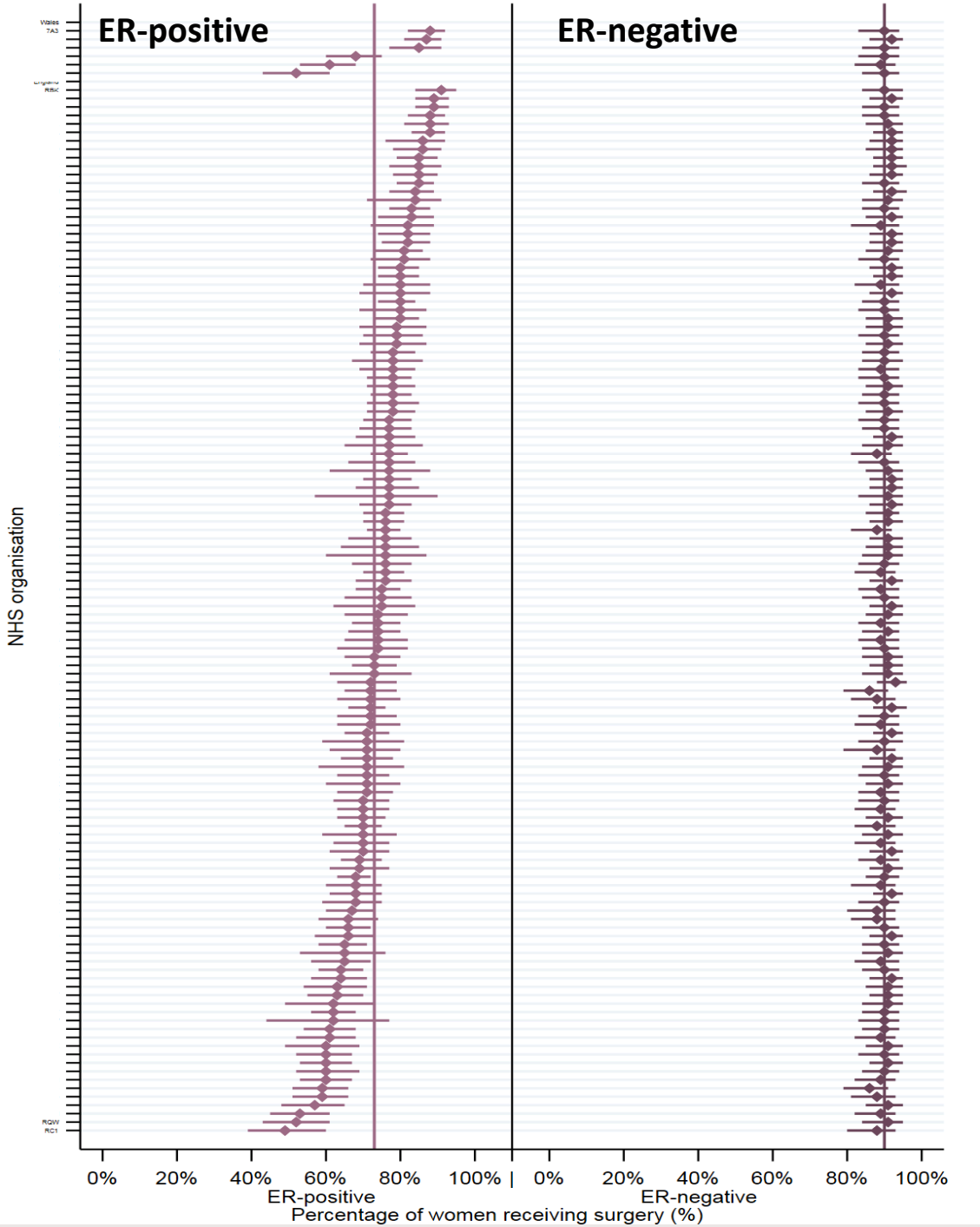
In the BCCOM audit (2007) mastectomy rates varied from 36% to 53% at regional level, and between 19% and 92% at the level of individual surgeon.

Increasing National Mastectomy Rates for the Treatment of Early Stage Breast Cancer

- SEER data 2000-2018 – 256000 women:
  - Age, race, marital status, geographic location, involvement of multiple regions of the breast, lobular histology, increasing T stage, lymph node positivity, increasing grade, and negative hormone receptor status were independent predictors of mastectomy

Source: Mahmood Annals of Surgical Oncology 2014

Risk-adjusted % of women aged 70+ years receiving surgery, by diagnosing NHS organisation and ER status →



Rate of mastectomies with immediate reconstruction by invasive status NHSBSP/ABS audit 15/16

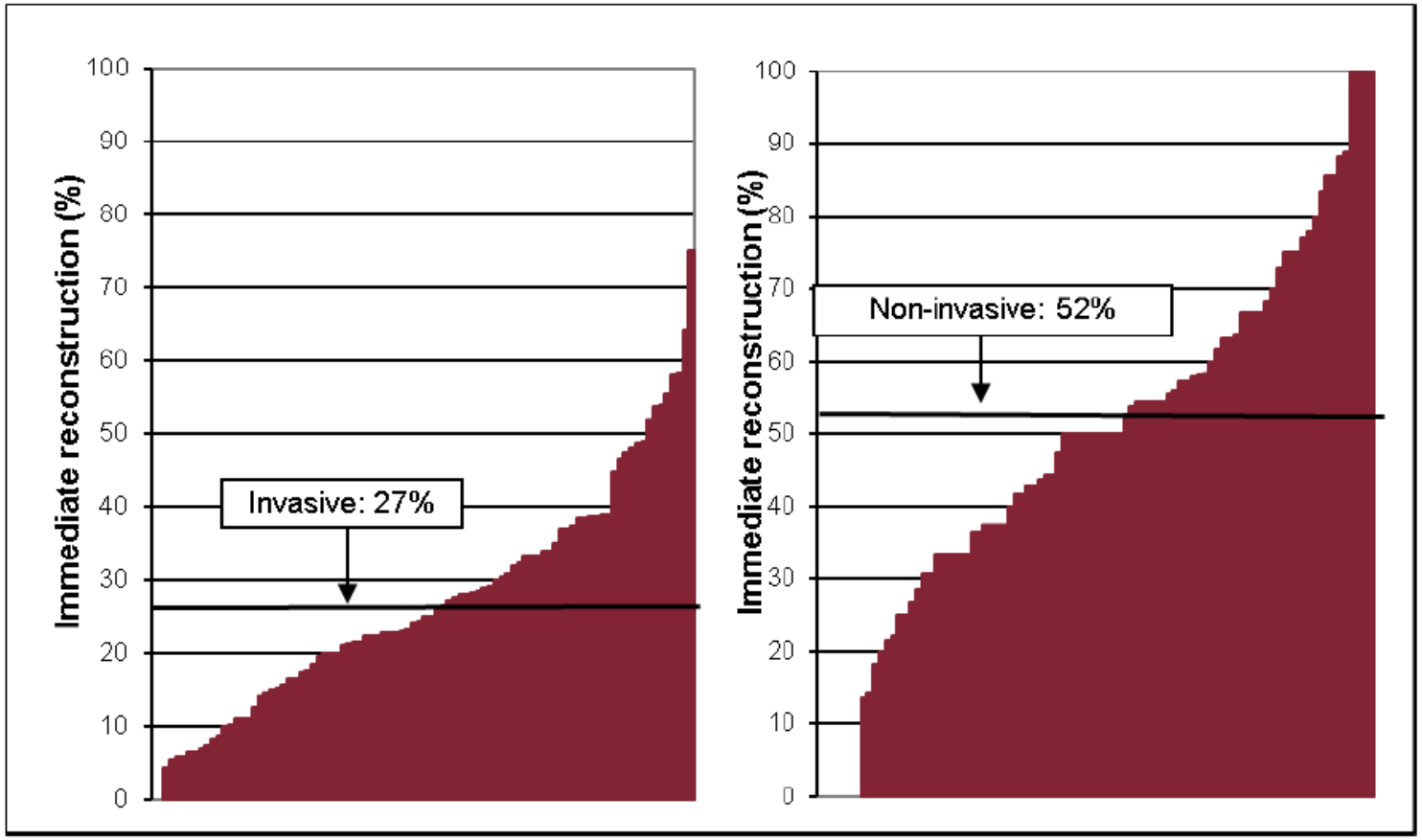


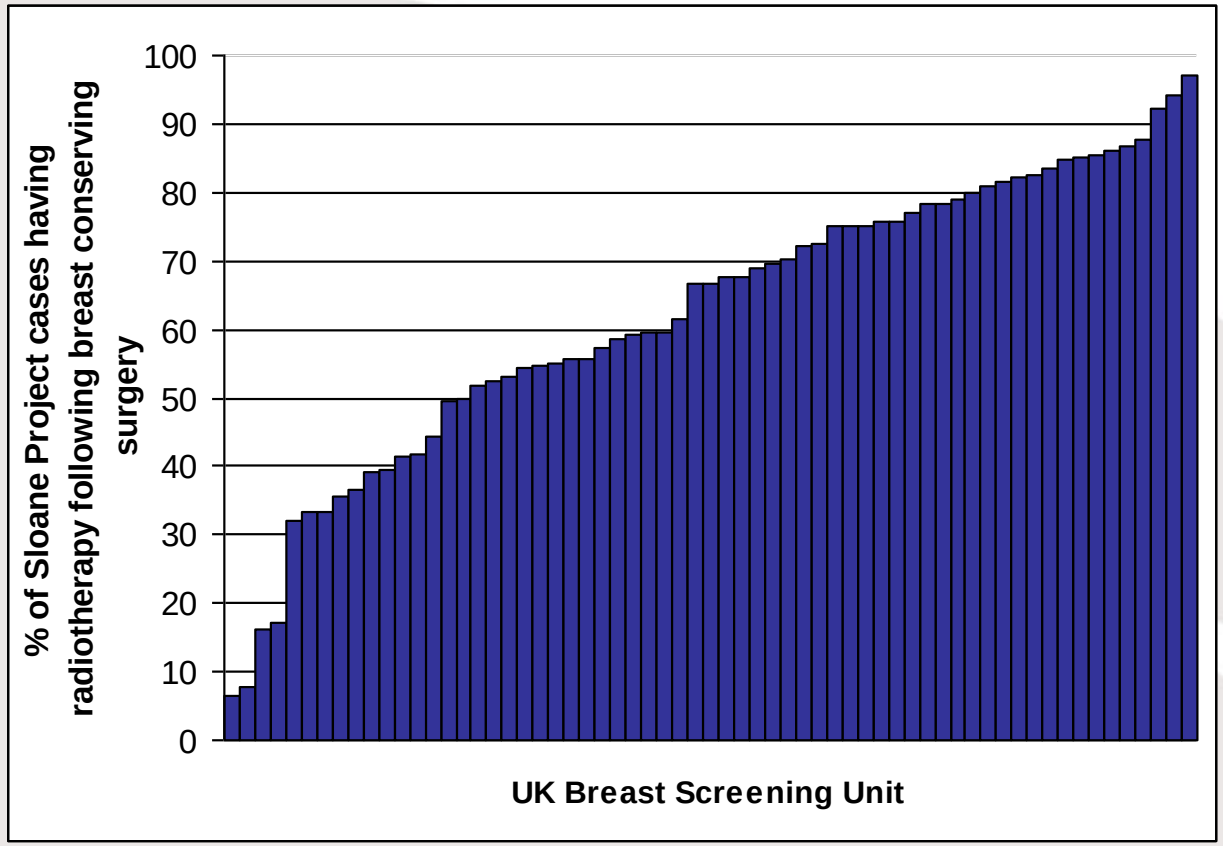
Figure 4: Variation between screening services in immediate reconstruction rates for invasive (left) and non-invasive cancers (right) (2015/16)

Radiotherapy (DCIS)

The Sloane Project
Understanding non-invasive breast disease

- Radiotherapy: % receiving radiotherapy after breast conserving surgery

62% BCS + RT



THE LANCET

Influence of clinician workload and patterns of treatment on survival from breast cancer

Year of diagnosis	Caseload (patients per year)				Total
	<10	10–29	30–49	⩾50	
1979–80	219 (9)	1215 (50)	290 (12)	700 (29)	2424 (19)
1981–82	213 (8)	1252 (50)	335 (13)	715 (28)	2515 (20)
1983–84	233 (9)	1215 (48)	354 (14)	708 (28)	2510 (20)
1985–86	249 (10)	1127 (43)	430 (17)	794 (31)	2600 (20)
1987–88	337 (12)	1017 (36)	548 (19)	910 (32)	2812 (22)

Table 3: **Number (%) of patients in each caseload category for each period**

Source: Sainsbury et al Lancet 1995

However, a clear relation was established between caseload and survival with a threshold for better outcome of 30 new patients per year.

Surgeon and Breast Unit Volume-Outcome Relationships in Breast Cancer Surgery and Treatment

Ailbhe M. McDermott, MD, Deirdre M. Wall, BSc,* Peadar S. Waters, MD,* Shan Cheung, MPhil,†*
Mark Sibbering, FRCS,‡ Kieran Horgan, MCh,§ Olive Kearins, MCh,† Gill Lawrence, MD,†
Julietta Patnick, FFPH,¶ Michael J. Kerin, MD, and on behalf of The ABS Audit Committee*

This study demonstrates that surgeon caseload is associated with differences in the index KPIs; surgical procedure of choice; sentinel node biopsy; and the administration of hormonal therapy, adjuvant chemotherapy and radiotherapy.

Source: McDermott AM, et al; ABS Audit Committee. Surgeon and breast unit volume-outcome relationships in breast cancer surgery and treatment. Ann Surg. 2013 Nov;258(5):808-13; discussion 813-4.

Evidence is mixed

Effect of surgeon's caseload on the quality of surgery and breast cancer recurrence

Päivi Peltoniemi [a,*], Heini Huhtala [b], Kaija Holli [c], Liisa Pylkkänen [a,c]

[a] Department of Palliative Medicine, Tampere University Hospital and Medical School, University of Tampere, 33014 Tampere, Finland
[b] School of Health Sciences, University of Tampere, Finland
[c] Department of Oncology, University of Turku, Finland

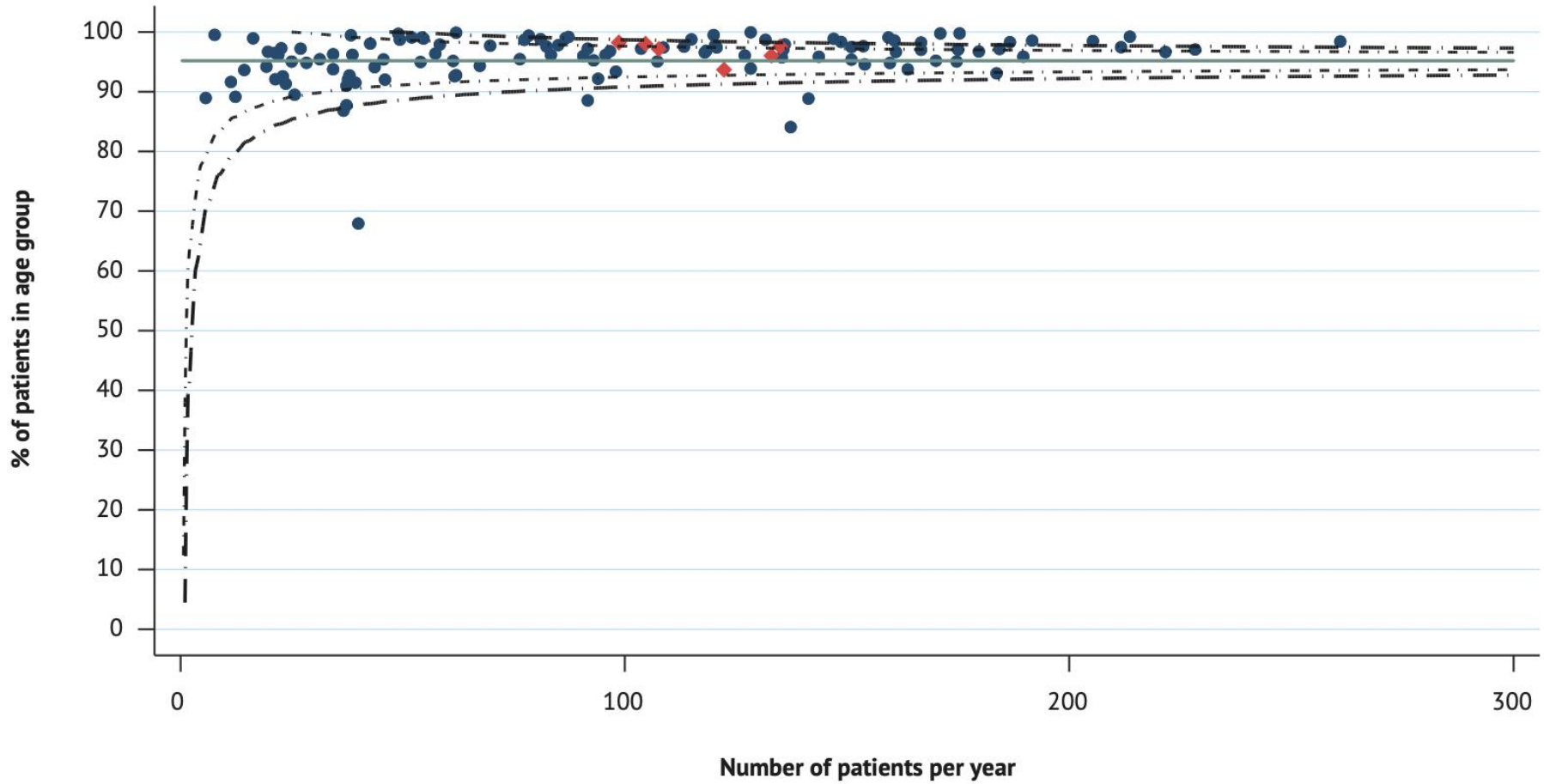
Even though there were no significant differences in the rate of local recurrences during this follow-up, quality of axillary surgery and the choice of surgical modality of the primary tumour should not depend on who the patient is treated by.

Source: Peltoniemi P et al. Effect of surgeon's caseload on the quality of surgery and breast cancer recurrence. Breast. 2012 Aug;21(4):539-43.

From NHSBSP audit 17/18

- 323 surgeons had an average annual caseload of less than 10 screen detected cancers

Figure 7.5: Funnel plot of adjusted rate of sentinel node biopsy in women aged 50–69 who had surgery for pathologically negative nodes in early invasive breast cancer, by diagnosing NHS trust and local health board



No shortage of guidelines!

Early and locally advanced breast cancer: diagnosis and management

NICE guideline
Published: 18 July 2018
www.nice.org.uk/guidance/ng101

Australian Government
Cancer Australia

Estimating the benefits of therapy for early-stage breast cancer: the St. Gallen International Consensus Guidelines for the primary therapy of early breast cancer 2019

NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)

Breast Cancer

Version 6.2020 — September 8, 2020

SIGN 134 • Treatment of primary breast cancer

A national clinical guideline

Early breast cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up†

CCO Cancer Care Ontario

DBCG DANISH BREAST CANCER GROUP

ASCO Special Articles

Postmastectomy Radiotherapy: An American Society of Clinical Oncology, American Society for Radiation Oncology, and Society of Surgical Oncology Focused Guideline Update

Treatment variation - common responses

- The data are wrong!
- Its patient choice!
- Tell me what good care looks like
- Its all down to case mix!
- Why does it matter?

Further observations

- Evidence into practice and treatment variation are difficult
- Causality is hard to prove
- Case volume relationships particularly so
- Deprivation = higher breast mortality
- But cancer datasets are improving
- Scrutiny of practice will increase
- Identifying benefits in RCTs is not enough
- More prescriptive national guidelines??

Thank-you

www.nabcop.org.uk

nabcop@rcseng.ac.uk

@NABCOP_news