Critical study of the nhs breast screening programme

Introduction

The NHS Breast Screening Programme began in 1988 and was set up by the Department ofHealthin response to the recommendations of a working group, chaired by Professor Sir Patrick Forrest. The report Breast Cancer Screening was published in 1986, and popularly known as The Forrest Report. NHSBSP began inviting women for screening in 1988 and started covering nationally in the mid 1990s. A report by the Department of Health Advisory Committee published in 1991 suggested that the programme would save 1, 250 lives each year by 2010(Breast Cancer Screening 1991: Evidence and Experience since the Forrest Report, Department of Health Advisory Committee, NHS Breast Screening Programme 1991). The NHS Breast Screening Programme is an effective part of the UK’s efforts to reduce the death toll from breast cancer. In September 2000, research was published which demonstrated that the screening programme had lowered mortality rates from breast cancer in the 55-69 age group. Early detection of breast cancer is an important factor in improving breast cancer survival. Breast screening is an opportunity for early detection of breast cancer. In 2010, research shows that benefits from screening mammography outweigh the harm in over diagnosis. . Between 2 and 2. 5 lives are saved for every over diagnosed case.

The aim of this essay is to critically analyse and evaluate the pathway through breast services with the relevant departments.

Pathway through the Breast services

Women registered with the General Practitioner, aged between 50 and 70 years old are routinely invited for breast screening at their local breast screening unit, it could be hospital based or in a mobile trailer. An invitation is sent once every three years. Women over 70 years old will not receive an invitation but they are encouraged to make their appointment for the breast screening programme. Enclosed in the invitation is a leaflet about the facts about the screening programme. The author finds the leaflet very helpful because it has a lot of facts about the breast screening programme, and its benefits. The leaflet sent is written in English. There is an available format with this leaflet from large print in English; for women who do not speak English as their first language, the leaflet is also available in other languages such as Arabic, Bengali, Cantonese, Polish, Punjabi and Urdu. It is even available in Braille format and a DVD for British sign language. The Department of Health Cancer Reform strategy announced that effective on 2012 the NHSBSP would be extending the invitation to women aged between 47 and 73 years old.

The author visited a mobile breast screening unit, based in the breast screening department car park. There were 55 patients booked on that day. There were two women who did not attend their appointment. The author observed that the unit was very relaxing despite the very busy list. Backgroundmusicwas playing while women waited for their mammograms to be performed. Music has been very successful in distracting patient’s attention from pain (Hawthorn and Redmond, 1998). The author strongly agrees with Hawthorn and Redmond that music helps in distracting ones

attention from pain. One woman made a comment that music helped her relaxed since it was her first breast screening and the woman was very anxious and a little bit nervous.

When a woman arrives for breast screening appointment, the radiographer will then greet the woman. The radiographer will check the woman’s personal details and reviews the questionnaire answered by the woman. In the x-ray room, the radiographer will explain the whole procedure such as the need of compression during the examination. The radiographer will answer all the woman’s questions before carrying out the examination. Giving proper applied compression is very important in producing a good mammography image (Bassett and Hendrick, 1994). Basett and Hendrick (1994) recommended that to give proper compression the radiographer should let women know the importance of compression, and inform when it is about to be initiated, it also should be done slowly and until the skin of the breast is tight without causing pain. After the mammogram, the woman was then given a leaflet for further information about the result of the examination, a contact number for inquiries and more information and it also states that there is a possibility for a recall for assessment.

The aim of breast screening assessment is to identify the abnormality found in the screening mammograms. If there is abnormality found, further tests are then needed. Testing for breast cancer should include a clinical examination, breast imaging, fine needle aspiration or core biopsy. These three tests are called triple assessment. Women recalled for further assessment from the breast screening, around one in six to have cancer (NHSBSP Pocket Guide, 2008).

The assessment clinics have breast care nurses that help women during assessment or women who are diagnosed to have breast cancer. Breast care nurse gives advice, support and information. According to the Breast Cancer Care and Royal College ofNursing, the key role of the breast care nurse during the treatment pathway is to give information and emotional support. They give information about treatments, options and what to expect during the entire treatment (Breast Cancer Care and Royal College of Nursing December, 2004). The author strongly believes that having a breast care nurse is crucially important to women who are undergoing treatment. It would make their life a bit easier during treatment because someone is there to listen and help them throughout. The author asked a woman on how helpful the breast care nurse during the treatment pathway, and the woman said that her treatment would be totally different without the help of the breast care nurse. The breast care nurse has helped the woman from the day she was recalled for further assessments from breast screening. The breast care nurse has given her a lot emotional support and has given her a lot of information during the treatment journey. The woman is extremely glad that someone is there to listen to all her worries during tough times.

The author visited an assessment clinic and observed the flow of the clinic that day. The author observed a woman recalled for assessment. The mammograms were read by two consultant radiologist. Double reading has been practiced in the breast screening programme. The opinion of the author is that having two readings is more effective than just having a single reading. Research shows that double reading may boost the number of cancers detected by some 9 to 15 percent (Brown et al, 1996). However,

around 13% of the health service costs happen during the breast screening assessment (Clark and Fraser, 1996). The author visited a busy assessment clinic; one the cases observed was that the reporting radiologists have found in the mammogram a calcification in the upper inner quadrant of the left breast that is why the woman was recalled for further tests. Additional views were suggested specifically, left lateral and left magnification views. After the additional views were done, the woman went to the examination room and the radiologist explained the suspected abnormality found in the mammograms and further imaging required to confirm or exclude any abnormality. After hearing out the Consultant Radiologist’s explanation regarding examinations needed during the visit, the woman got so anxious and stressed out. The breast care nurse was there to give support in these times. A woman scheduled for breast biopsy procedures suffersanxietyabout the result of theirdiagnosticprocedures. The author believes that breast care nurse plays a very important role in the assessment team. Preoperative nurses have special ways in providing quality nursing care for patients waiting for breast biopsy procedures and their definitive diagnosis (Deane, 1997). The woman had a clinical examination; Stereotactic guide biopsy with specimen radiography was performed. The radiologist took five flecks of representative calcification and was sent to the pathology department for analysis. Result will be ready for the multi-disciplinary team for review in two days. According to the clinical guidelines for breast screening cancer assessment, women who will have further tests should have their results discussed in a multidisciplinary meeting. There are two routine outcomes for assessment; the woman will still be invited for the breast screening

programme or the woman will have further treatment (NHSBSP, Publication 49).

The author visited a “ one stop breast clinic” at a local breast care unit. Most patients were referred by their GP and there was a patient referred from breast screening assessment. A specialist should see GP referrals or referrals from the breast screening unit within two weeks from referral. Cancer reform strategy 2007 announced that in December 2009, all patients referred to a specialist with breast symptoms even if cancer is not suspected should be seen within two weeks of referral (DOH, 2007). The clinic had a mixture of patients. There were new referrals from the GP, follow up appointments from previous treatment and follow up for results of tests. The clinic had a consultant breast surgeon, registrar, breast care nurses, consultant radiologist, radiographer, and consultant pathologist, consultant oncologist. They are referred as the breast care team. The Surgical guidelines for the management of breast cancer, Association of Breast Surgery, BASO 2009 states that it is now widely accepted that breast care team should be provided by breast specialists in each discipline and that multidisciplinary team form the basis for best practice. “ One Stop Clinic” is similar to the assessment clinic for women recalled from breast screening.

The author observed that triple assessments were done just like women recalled for further assessment from breast screening and these tests are based on clinical examination, breast imaging, fine needle aspiration or core biopsy. Men who have suspected breast cancer will have the same investigations (NICE guidelines, 2009).

The author’s opinion, it is important that every woman or man referred to a Consultant Breast Surgeon should have triple assessment, if possible for accurate diagnosis and should be done at the same visit. “ Routine use of triple assessment can increase the speed and accuracy and reduce the cost of diagnosis. When the three tests give consistent results, a definite positive or negative diagnosis can be given 99% of the time. Thus minimises the need for open biopsy, thus preventing unnecessary surgery and reducing anxiety (NICE, 2009).” National Institute for Clinical Excellence suggested that the triple assessment should be available to patients with suspected breast cancer at a single visit (NICE, 2009).

The author observed another woman in the outpatient clinic, a woman referred from breast screening that had shown in the mammograms clusters of micro calcification in the right breast. Core biopsy was done during her first visit in the assessment unit and in which turned out to be breast cancer. The woman’s case was reviewed with the Multidisciplinary team and further treatment was recommended. The woman was so anxious, and felt so hopeless but with the help of the breast care nurse to give support and advice, the woman felt a little better. Treatment was discussed during the visit.

Another woman referred by the GP complaining on having breast lumps. The Consultant surgeon reviewed the woman’s notes before bringing the woman into the room. After reviewing the notes, the breast care nurse then brought the woman in for clinical examination. The surgeon thoroughly examined the woman’s breast. The surgeon then wrote down an imaging request form with its clinical indications for a Mammogram. The author then accompanied the

woman to the Mammography Section of the Breast Unit and was then met by the radiographer. The radiographer then explained the examination, like how many views to take, and the need to compress both breast and informed the woman might feel a little bit uncomfortable. The author has observed that the radiographer have explained very well about what happens during the whole examination. Goodcommunicationbetween a radiographer and patients is an important factor.

The author visited the Pathology department and observed what happens in the department. NHSBSP uses triple approach, known as triple assessment. Having a fine needle aspiration or breast core biopsy is part of the triple assessment.

Fine needle aspiration entails placing a very thin needle inside the mass and extracting cells for microscopic evaluation. The samples are then smeared on a microscope slide and allowed to dry in air and fixed by spraying, or immersed in a liquid. The fixed smears are then stained and examined by a pathologist under the microscope. According to Bateman (2006), fine needle aspiration is the fastest and easiest method of breast biopsy, and the results are rapidly available, fine needle aspiration cannot distinguish between in situ and invasive carcinoma.

Core biopsies are samples of cells are taken from the lump or area of abnormality using a needle. It can be performed under local anaesthesia in the outpatient setting. The sample will be sent to the Pathology department. The Consultant Pathologist will evaluate the sample.

The accurate diagnosis of breast cancer and the pathological assessment of breast cancer tissue are big responsibilities by pathologists working within the field of breast disease. It is very important to distinguish the pathological changes of benign breast disease from those of early and established breast cancer. Once cancer is confirmed, the pathologist is required to provide an evaluation of the pathological features determining prognosis and the requirement for further treatment (Bateman, 2006). The author has realized that diagnosing a breast cancer relies on the pathological assessment of the breast cancer tissues and that the Consultant pathologist plays a very important role in giving the diagnosis accurately and the pathological assessment of the breast cancer tissue. The consultant pathologist is responsible in establishing the pathological assessment of the breast cancer tissue. The author’s opinion is that excellent histological diagnosis plays a very important part to breast cancer staging and management.

Woman diagnosed with breast cancer picked up from breast screening should be under the care of the Multidisciplinary team. There are some factors that they need to be considered on what treatment is best. The consultants will consider the stage and grade of cancer, health, and whether the woman has been through menopause. Different methods define the stage of cancer; the TNM system of staging describes the tumour size, number of affected lymph nodes, and what extent the cancer has spread (breakthrough). When treating cancer, the breast consultant will discuss on what treatment is best for the patient.

Before an operation is done, the surgeon will talk to the woman concerned about the best surgery that should take place for the woman’s case.

According to the BASO surgical guidelines (2009), surgery should only be performed by a specialist who specialize breast diseases and who performs surgery of at least 30 cases per year The NHS Cancer Plan sets a maximum of one month wait from the date of diagnosis. Women diagnosed with breast cancer are given their first treatment within 2 months of an urgent GP referral or women who came from breast screening. Surgery is often the first treatment for breast cancer to remove cancerous tissues, and to find out if the lymph nodes are affected. Surgery is usually the first line of attack against breast cancer. A range of operations should be available. If the cancer is not too large or diffuse, surgical options include mastectomy and breast conserving surgery. In such cases the choice should be made jointly by the surgeon and the patient, who should be fully informed of all opinions and their potential risks, benefits and implications for further treatment (NICE, 2002). Before the operation, patient will be seen by a member of the breast surgical team for a pre-admission appointment. The patient will stay overnight to prepare her for the operation the next day. Surgical considerations are; wide local excision is the removal of the breast tumor and some of the normal tissue that surrounds it. The breast is left intact with less disfigurement.

Sentinel lymph node biopsy involves a tiny incision in the axilla and removing one to four lymph nodes, before having this surgery, radioactive tracer is injected two to twenty-four hours prior to surgery. When patient is already under general anaesthesia, blue dye will then be injected around the areola. Both radioactive tracer and the blue dye will help in identifying the sentinel lymph nodes during the operation, once they are identified the

consultant breast surgeon will then remove it and sentinel lymph nodes are sent to the pathology department for analysis. Axillary clearance takes place if the sentinel lymph nodes are affected by cancer the consultant breast surgeon will remove the entire lymph glands in the axilla. If cancer cells are found in the sentinel lymph nodes patients are given another operation in about two weeks time or after the pathology report is available. The second operation involves the removal of further lymph nodes in the axilla. Research shows that 20, 000 women who will undergo sentinel node biopsy will be spared from unnecessary breast cancer surgery each year (Goyal and Mansel, 2008). According to Professor Mansel, ninety two percent of women who had sentinel node biopsy had a quick recovery and they were able to do their normal activities after three months compared to women who had a conventional operation and also they only stayed one night at the hospital compared to four nights.

Under the written breast local guidelines, a woman who has had surgery of the breast should be identified on which adjuvant treatment should be given consideration(BASO, 2009.). Adjuvant treatment includes radiation therapy, endocrine therapy, hormone therapy and targeted therapy.

Radiation therapy is needed to the remaining breast tissues after an operation. It is often used in combination with other treatments, such as chemotherapy to shrink the size of the tumour before removing it. Radiation therapy to the breast is a localised treatment. The target is directly aimed to the cancer. It uses high-energy rays to stop cancer cells from spreading and growing. It is often used to destroy remaining breast cancer cells in the breast, chest wall, or axilla. The oncologist may suggest treatment in a

specific area; it could be the breast alone, axilla and supraclavicular area. The author visited the Radiation Therapy and observedwhat happens in the department. The author observed that for the patient’s first appointment will be a planning session in the planning CT scanner or in a stimulator. This is not formal consultation. The main purpose of this first visit it to plan and arrange the radiation therapy. The author observed a woman for her first appointment. The woman’s breast cancer was detected through breast screening. When the woman arrived for her first appointment, the woman was asked for her details and appointment card then she was then told by the receptionist to go to the stimulator. The stimulator is where the planning takes place. This stage helps the consultant oncologist to target the specific area for treatment. Measurements are measured accurately and ink marks are marked on the patient’s skin for the accurate target. This stage helps the consultant oncologist to target the specific area for treatment. After all accurate measurements are recorded the next stage would be treatment. The radiographers are not in the room with the patient although they are equipped with video camera and intercom so they can see and hear the patient in the treatment room at all times. The Radiation therapy team consist of radiographers, physicist and oncologists. The author observed that the unit is very busy and not enough staff for a very busy unit. The author asked the radiographer about patient waiting during the visit and the specialist radiographer said that it is quite difficult to judge how long each patient will take and also to get start the radiation therapy process, there is a long wait for appointment for radiation therapy. Patient can get an appointment as long as three months. According to Dr Michael Williams , vice president of the Royal College of Radiologists, in The Telegraph article, he

said current waiting times were “ simply not acceptable”. There are shortage of radiographers and radiation therapy units. The author believes that if the government invests and expands the coverage for radiation therapy units in various places in the United Kingdom then waiting time will be reduced and patient anxiety will lessen.

The oncology unit provides a wide range of services such as clinical and support services. The breast care team in this unit includes a consultant oncologist, two breast care nurses, clinical oncology assistant, and nursing team. The breast care team work closely together with the radiology department at the local NHS hospital to ensure that patients are given the multidisciplinary approach. Patients with breast cancer are given a holistic service in their battle with breast cancer. There is a 24 hour emergency contact number for patients undergoing chemotherapy. The breast care nurses in this unit are always ready to respond to patients needs and concerns during their treatment.

After treatment for breast cancer, women should have a care plan with the GP or a Specialist to detect local recurrence or side effects of any treatment the woman has had. A written care plan should be made for every woman diagnosed with breast cancer. Dates of review for any adjuvant therapy, details of surveillance mammography, and contact details for any urgent referral to a specialist and support services should be in the care plan. Copies are given to the general practitioner and to the woman (NICE, 2009.) Breast care service does not end after having treatment. After treatment, women are given follow ups and are offered yearly mammography. Women

who are part of the NHSBSP are given yearly screening for five years and will have the routine screening every three years after that.

Conclusion

The author has learned and gained a lot of knowledge through this essay. Research and visits to various departments that are part of the pathway through breast care services has been extremely educational and helpful in the author’s profession as a radiographer. The pathway through breast services with the relevant departments work really hard as a team. Each individual who is part of the pathway is very dedicated, committed and has the understanding to women undergoing breast screening and to women fighting with breast cancer. The experience that the author had with all the research and visits is very valuable; it made the author become a better radiographer and has gained themotivationto pursue Post Graduate Award in Mammography. It has given the author to put into practice all the experiences learned from Consultants, nurses and patients during the department visits. As a future mammographer, it has instilled in the author’s mind and heart that high quality standards should be carried out at all times, it is vital to follow the quality assurance guidelines for radiographers to be able to give a first class service.

NHSBSP was established in 1988. In the last 22 yrs since NHSBSP has started its service for breast screening to women in England, between 50 to 70 years old every three years, over 100, 000 women had their breast cancer detected in this programme. The author therefore concludes that the programme is a vital factor in detecting early stage of breast cancer and it definitely does save many lives.

The author would like to thank the people behind the NHSBSP for their commitment and effort to make this programme a success, job well done! The author wishes continued success with this programme. From 1988 up to the present, there have been a lot of changes with NHSBSP, like in 2008; the government invested ? 100 million in digital mammography equipment throughout the NHS and also the programme will expand its age group between 47- 73 years old in 2012. Therefore, the author concludes that with these changes, a lot of women will benefit more and will be given the best service and with the latesttechnologythere is to offer in the pathway through breast services.

Through the years, breast care awareness has increased rapidly with the help of the NHS Breast Screening Programme. “ Be Breast Aware” leaflets from the NHS Cancer screening programme is available and it gives a lot of information on how to be become aware of the changes of the breasts , what normal breasts feels like, and what changes you need to look out for . A lot of women nowadays even men are breast aware with the help NHSBSP campaign. It is essential to be breast aware before it is too late in the detection of any breast diseases. The author agrees with the facts, research, studies and department visits gathered together, the author concludes that having routine breast screening definitely helps in detecting early stage of breast cancer.

The author would like to extend a big heartfelt thank you to the breast care team and to all those individuals who have given their time and effort during the authors’ department visits even with their busy tight schedule. The author is very much thankful to the women who had given their time with

the author in sharing their bad and good experiences with their treatment journey.

The breast services pathway is continually improving and the author concludes that in order to improve the pathway in breast services, it is important thatconsultants, radiographers, breast care nurses, and the rest of the staff who work in the relevant departments in the pathway through the breast services should work hand in hand as a team. Good communication within the team and to the women that belongs in the NHSBSP are key factors to ensure thatgood service is maintained for each individual undergoing breast screening or any examination in relation to breast diseases.

References

Hawthorn, J. and Redmond, K (1998). Pain: causes and management. Blackwell Sciences Ltd., UK.

Breast Cancer Care and Royal College of Nursing (2004). Time to care: maintaining access to breast cancer nurses. [Online]. Available from: http://rcn. org. uk/_data/assets/pdf_file/0008/78641/002494. pdf .[Accessed 18 December 2010]

Brown, J. et al. (1996). Mammography screening: an incremental cost effectiveness analysis of double versus single reading of mammograms. March, 312 (7034). [Online]. Available from: http://bmj. com/content/312/7034/809. full. Date accessed: 20 December 2010

NHSBSP (2001). NHSBSP Publication No. 49, NHS Cancer Screening Programmes. [Online]. Available from: http://cancerscreening. nhs. uk/breastscreen/publications/nhsbsp49-1st. pdf. [accessed: 2 January 2011].

National Institute for Health and Clinical Excellence Guidelines(2009) Early and Locally Advanced Breast Cancer: Diagnosis and Treatment. The National Collaborating Centre. [Online]. Available from: http://www. nice. org. uk/nicemedia/pdf/CG80NICEGuideline. pdf. [Accessed 3 November 2010].

Deane, K A (1997). The Role of the Breast Clinic Nurse. AORN Journal. 66(2): 304-7, pp 304-310.

Goyal , A and Mansel, R. (2008). Current opinion in oncology. Recent Advances in Sentinel Lymph Node Biopsy for Breast Cancer. November, 20 (6), pp 621-626.

Bassett, L and Hendrick R E. (1994). Quality Determinants of Mammography: Clinical Practice Guidelines. AHCPR Publication. 13. pp 23-24.

British Association of Cancer Oncology (2009). Surgical Guidelines for the Management of Breast Cancer. Elsevier Publication. [Online]. Availablefrom: http://www. baso. org. uk/Downloads/YEJSO_2782. pdf .[Accessed: 20 January 2011].

NHSBSP, (2008). Breast screening: a pocket guide. Department of Health Publications. [Online]. Available from: http://www. cancerscreening. nhs. uk/breastscreen/publications/nhsbsp-pocket-guide-2008. pdf . [Accessed 26 October 2010].

Bateman, A C. (2006). Womens health medicine. Pathology of Breast Cancer. January, 3 (1), pp 18-21. [Online]. Available from: http://download. journals. elsevierhealth. com/pdfs/journals/1744-1870/PIIS1744187006001193. pdf . [Accessed 12 January 2011].

Donnelly, L. (2007). Government pledges to cut radiation therapy wait. The Telegraph. 2 December 2007. [Online]. Available from: http://www. telegraph. co. uk/news/uknews/1571199/Government-pledges-to-cut-radiotherapy-wait. html .[Accessed 27 January 2011].

Does breast screening save lives?. [Online]. Available from: http://www. cancerscreening. nhs. uk/breastscreen/save-lives. html . [Accessed 29 October 2010].

Going further on cancer waits: the symptomatic breast two week wait standard (2009). [Online]. Available from: http://ncin. org. uk . [Accessed 24 January 2011].

Healthcare services for breast Cancer (2002). Improving Outcomes in Breast Cancer. National Institute for Clinical Excellence. [Online]. Available from: http://www. nice. org. uk/nicemedia/live/10887/28766/28766. pdf .[Accessed 3 November 2010].

Breakthrough Breast Cancer. The best treatment. [Online]. Available from: http:// www. breakthrough. org. uk . [Accessed 18 November 2010].