ASUGI
Azienda Sanitaria Universitaria Giuliano Isontina
REGIONE AUTONOMA FRIULI VENEZIA GIULIA

Breast Unit Trieste

Screening e centri di senologia, punti di incontro: le piccole lesioni dello screening

Quando il trattamento diventa sovratrattamento

Marina Bortul - Trieste

Sovradiagnosi:

Identificazione lesioni (neoplasie e non) che non pongono a rischio la vita della paziente

Sovratrattamento:

Adozione della medesima strategia terapeutica utilizzata per forme piu' aggressive

(chirurgia, radioterapia, terapia sistemica)

ONE SIZE FITS ALL

Commentary

Addressing Overtreatment in Breast Cancer

The Doctors' Dilemma

Steven J. Katz, MD, MPH[1]; and Monica Morrow, MD[2]

Cancer 119:3584; 2013

Overdiagnosis and Overtreatment of Breast Cancer

By Michael Alvarado, MD, Elissa Ozanne, PhD, and Laura Esserman, MD, MBA

The Breast 31 (2017) 284–289

Contents lists available at ScienceDirect

The Breast

journal homepage: www.elsevier.com/brst

ELSEVIER

Original article

Over surgery in breast cancer

Fiona MacNeill [a, *], Andreas Karakatsanis [b]

[a] Royal Marsden Hospital, Fulham Road, SW3 6JJ, London, UK
[b] Section for Endocrine and Breast Surgery Department for Surgical Sciences Uppsala University Hospital, SE 751 85, Sweden

AJR FOCUS ON:

Current Issues in the Overdiagnosis and Overtreatment of Breast Cancer

Debra L. Monticciolo[1]
Mark A. Helvie[2]
R. Edward Hendrick[3]

OBJECTIVE. The discovery of breast cancer at earlier stages with screening brings the risk that some cancers will be overdiagnosed or overtreated. Reasonable estimates show the overdiagnosis rate due to screening mammography to be low, 1–10%.

CONCLUSION. Overdiagnosis should not be used as a reason to delay the onset or decrease the frequency of screening, because neither strategy will decrease overdiagnosis. Improvements in personalized treatment will diminish the morbidity of treatment and, therefore, the significance of overdiagnosis.

Breast Cancer Research December 2005 Vol 7 No 6 Paci and Duffy

Review

Overdiagnosis and overtreatment of breast cancer

Overdiagnosis and overtreatment in service screening

Eugenio Paci[1] and Stephen Duffy[2]

[1]Unit of Clinical and Descriptive Epidemiology, CSPO, Research Institute of the Tuscany, Via di SanSalvi, Florence, Italy
[2]Centre for Epidemiology, Mathematics and Statistics, Wolfson Institute of Preventive Medicine, Charterhouse Square, London EC1M 6BQ, UK

Corresponding author: Eugenio Paci, e.paci@cspo.it

Published: 10 November 2005 *Breast Cancer Research* 2005, **7**:266-270 (DOI 10.1186/bcr1339)

Commentary

Addressing Overtreatment in Breast Cancer

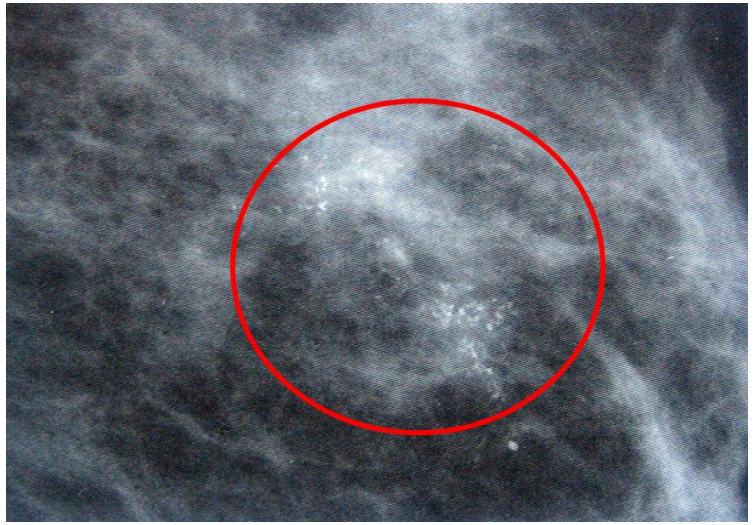
The Doctors' Dilemma

Steven J. Katz, MD, MPH[1]; and Monica Morrow, MD[2]

Cancer 119:3584; 2013

Quali sono le lesioni piu’ frequentemente diagnosticate in corso di screening?

- **B3**
- **CDIS**
- **Tu invasivi**



…..Quali sono le **meno pericolose** e con **prognosi migliore?**

…. Per quali evitare sovratrattamenti?

Le piccole lesioni dello screening
B3

- **ADH/AIDEP, FEA, LN, PL, PT, RS**
- **! Upgrade (3-20%)**
- **Dg finale di BENIGNITA'**

Ann Surg Oncol (2021) 28:5156–5157
https://doi.org/10.1245/s10434-021-09845-8

Annals of SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

ASO AUTHOR REFLECTIONS

ASO Author Reflections: "High-Risk" Lesions of the Breast: Low Risk of Cancer, High Risk of Overtreatment

Jennifer L. Marti, MD, FACS

Divisions of Breast and Endocrine Surgery, Department of Surgery, Weill Cornell Medicine, New York-Presbyterian Hospital, New York, NY

Le piccole lesioni dello screening
B3

Ann Surg Oncol (2021) 28:6041–6043
https://doi.org/10.1245/s10434-021-09978-w

Annals of
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Check for updates

ASO AUTHOR REFLECTIONS

ASO Author Reflections: A Plea Against Blind Fear of Benign 'High-Risk' Lesions of the Breast: Five Recommendations to Minimize Unnecessary Treatment

Jennifer L. Marti, MD, FACS

Divisions of Breast and Endocrine Surgery, Department of Surgery, Weill Cornell Medicine, Weill Cornell Breast Center, New York-Presbyterian Hospital, New York, NY

- **Rimodulazione terminologia Rx**
- **Stop chirurgia in ogni caso**
- **Discussione congiunta**
- **Considerare recall per anomalie Rx a basso rischio (?)**
- **Condivisione decisione**

Le piccole lesioni dello screening
B3

- **Quando la CHIRURGIA?**
  - **ADH, PL con atipia, PT**
  - **Discordanza rx ed anat. patologica**
- **VAE (! 4g)**

Current Breast Cancer Reports (2019) 11:83–88
https://doi.org/10.1007/s12609-019-0310-6

BREAST CANCER IMAGING AND SCREENING (N SHARMA, SECTION EDITOR)

Check for updates

Management of B3 Lesions—Practical Issues

Abeer M. Shaaban[1] · Nisha Sharma[2]

Published online: 25 April 2019

Abstract
Purpose of the Review Breast lesions of uncertain malignant potential (B3) are a heterogeneous group of diagnostic entities that can be associated with atypia. These are associated with in situ or invasive malignancy in 20–30% of cases. The management of those lesions has been both controversial and challenging for the multidisciplinary teams.
Recent Findings This is an up-to-date review of the current International Consensus on the management of B3 lesions with emphasis on the practical considerations.
Summary Through multidisciplinary management pathways, the vast majority of B3 lesions should be managed by vacuum-assisted excision, rather than surgical excision. Exceptions to this pathway and the rationale for surgical excision are discussed.

Keywords B3 lesions · Upgrade rate · Carcinoma in situ · Atypical ductal hyperplasia

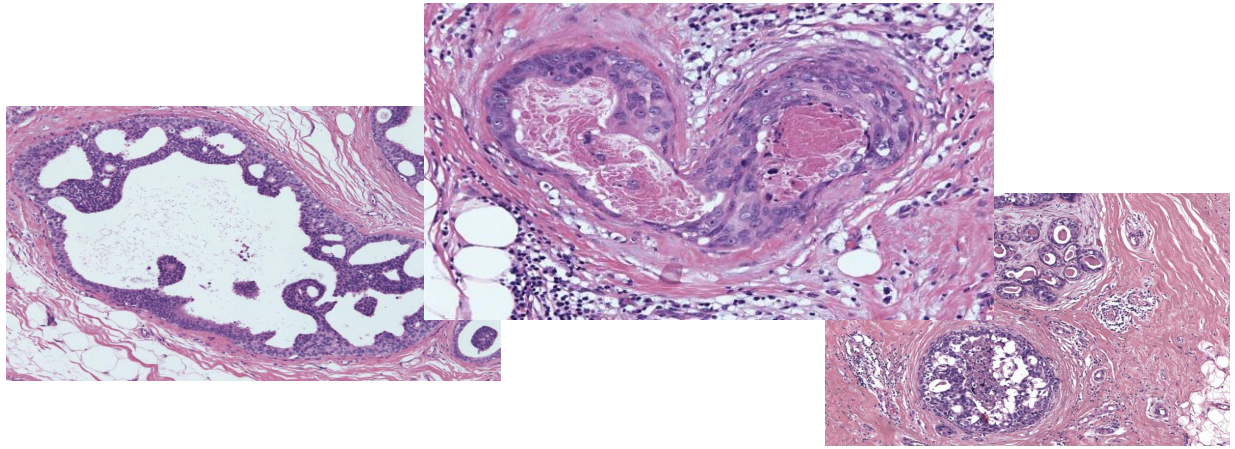
ELSEVIER

Clinical Radiology
Volume 73, Issue 8, August 2018, Pages 682-692

NHS Breast Screening multidisciplinary working group guidelines for the diagnosis and management of breast lesions of uncertain malignant potential on core biopsy (B3 lesions)

S.E. Pinder [a], A. Shaaban [b], R. Deb [c], A. Desai [d], A. Gandhi [e], A.H.S. Lee [f], S. Pain [g], L. Wilkinson [h], N. Sharma [i]

Le piccole lesioni dello screening



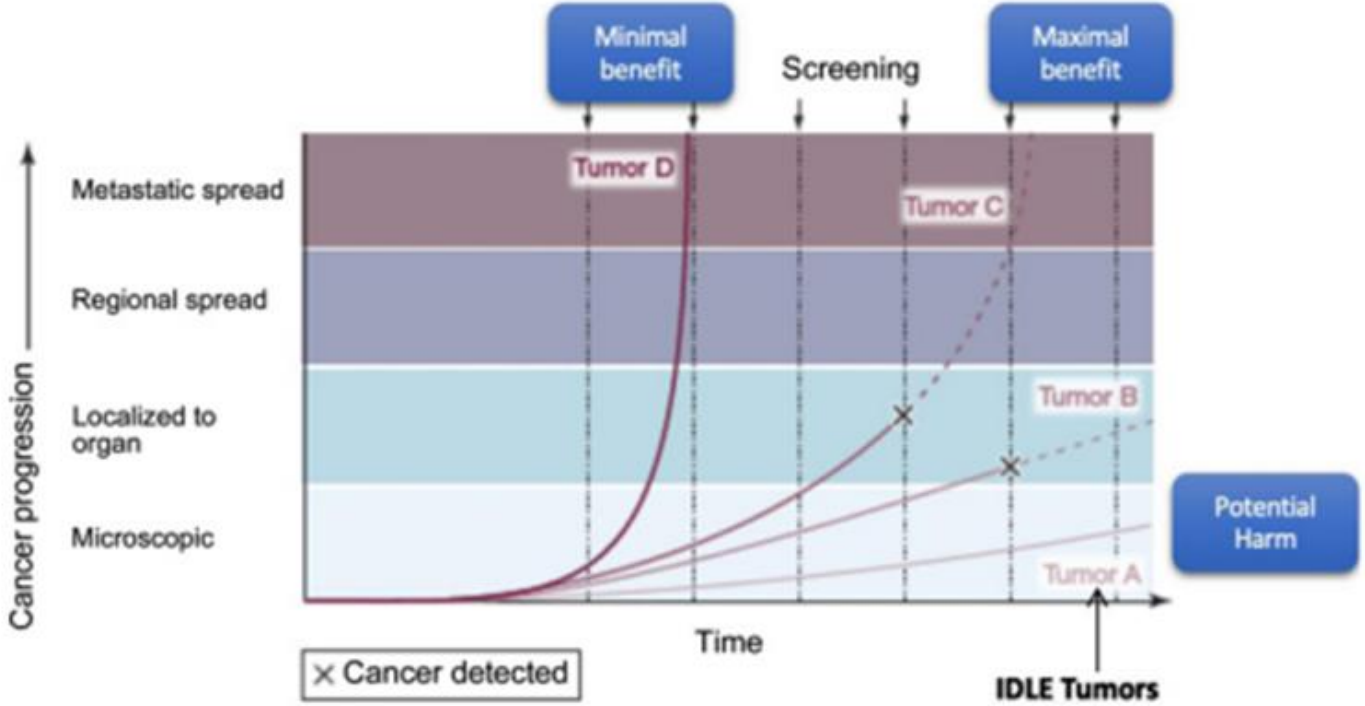
- **CDIS**
  - basso, medio, alto grado

- **Carcinomi infiltranti**
  - T1a,b N0
  - G1
  - Tubulari, mucinosi, cribriformi
  - Luminali, Ki67 < 10%

CEBP **FOCUS**

The Evolution of Our Understanding of the Biology of Cancer Is the Key to Avoiding Overdiagnosis and Overtreatment

Kelly Hewitt[1], Jennifer Son[1], Alexa Glencer[1], Alexander D. Borowsky[2,3], Matthew R. Cooperberg[4,5], and Laura J. Esserman[1,3]



Screening should reflect our new understanding of breast cancer biology

…. la sfida si basa sul riconoscimento

- Tu indolenti veri
- Tu a lento accrescimento meno aggressivo
- Tu a rapido accrescimento piu’ aggressivo

→ priorità di trattamento

Screening
! Rapporto costo/beneficio

- > diagnosi ca …
- a prognosi migliore

- sovradiagnosi
- Sovratrattamento ….

….. eccellente outcome vs sequele trattamento relate

Breast Cancer Steering Committee of the National Cancer Institute

Highest priority

"… decreasing toxicity/treatment/cost associated with therapy with negligible clinically meaningful benefits"

…. De-escalation

(Nat Can Inst 2015 Strategic Priorities:Breast Cancer Steering Committee)

Modern Pathology
https://doi.org/10.1038/s41379-020-00665-x

USCAP

LONG COURSE ARTICLE

Diagnosis of ductal carcinoma in situ in an era of de-escalation of therapy

Stuart J. Schnitt[1,2]

Received: 25 June 2020 / Revised: 13 August 2020 / Accepted: 13 August 2020

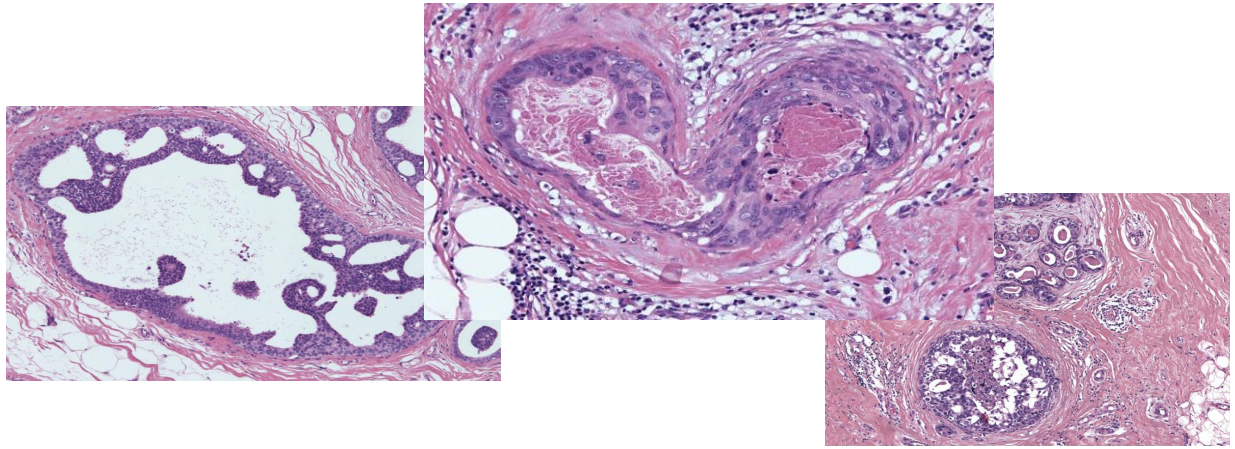
-Aumento diagnosi con screening (20-25% nuovi casi)

-**Eterogeneita'**

- Variabilita' clinica
- Potenziale evolutivo

Le piccole lesioni dello screening

- **CDIS**
  - basso, medio, alto grado



→Escludere contestuale invasività
→Prevenirne l'evoluzione
→Ridurre il rischio di recidiva locale

Per quali CDIS ipotizzare un sovratrattamento?

Overcoming Barriers in Ductal Carcinoma In Situ Management: From Overtreatment to Optimal Treatment

Jean L. Wright, MD[1]; Habib Rahbar, MD[2]; Samilia Obeng-Gyasi, MD[3]; Ruth Carlos, MD[4]; Judy Tjoe, MD[5]; and Antonio C. Wolff, MD[1]

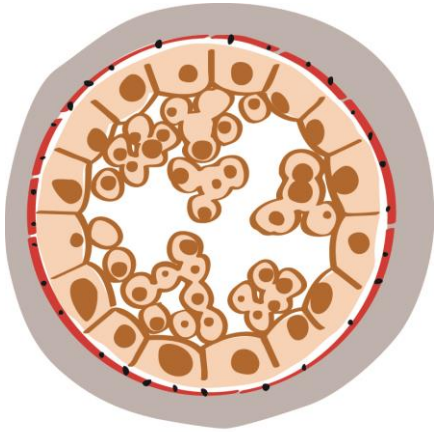
Check for updates

Wright J l:,JCO, 2021

Poche definite conoscenze

Mancanza di chiari markers predittivi di recidiva e progressione a ca invasivo

Sopravvivenza a 10aa 98% (Hwang S., 2020)



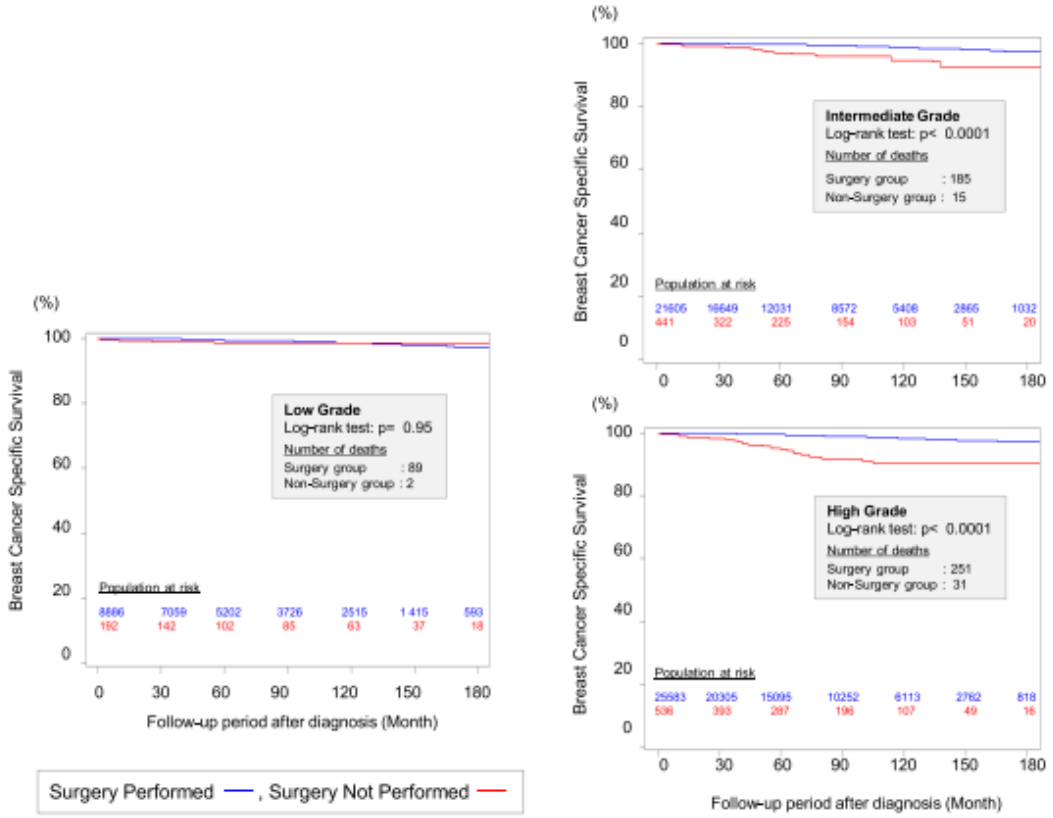


FIGURE 1 | Kaplan–Meier curves for breast cancer-specific survival between surgery group and non-surgery group among patients weighted by inverse propensity score. Sagara et al. (25)

ers
ology

MINI REVIEW
published: 28 August 2017
doi: 10.3389/fonc.2017.00192

Paradigm Shift toward Reducing Overtreatment of Ductal Carcinoma *In Situ* of Breast

*Yasuaki Sagara[1,2,3], Wong Julia[4], Mehra Golshan[5] and Masakazu Toi[1]**

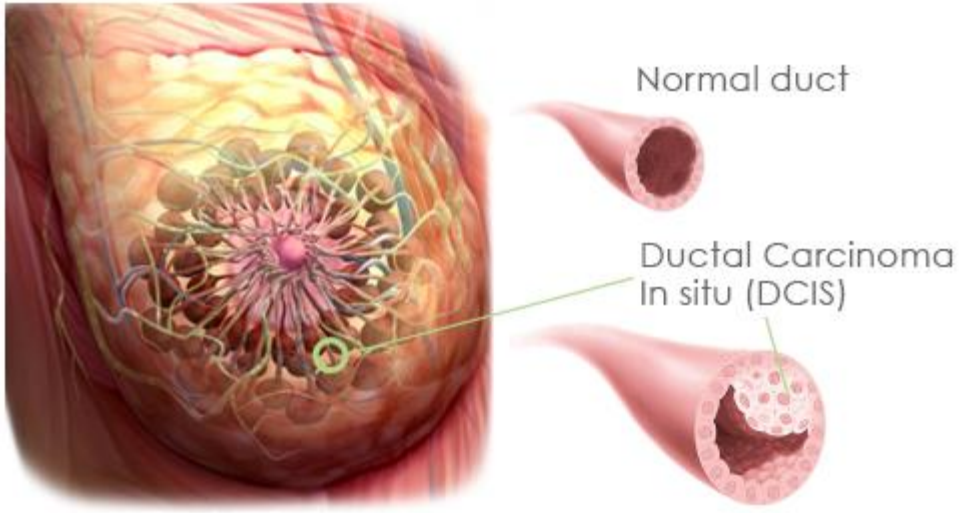
SEER 57.222 CDIS/1169 non operati

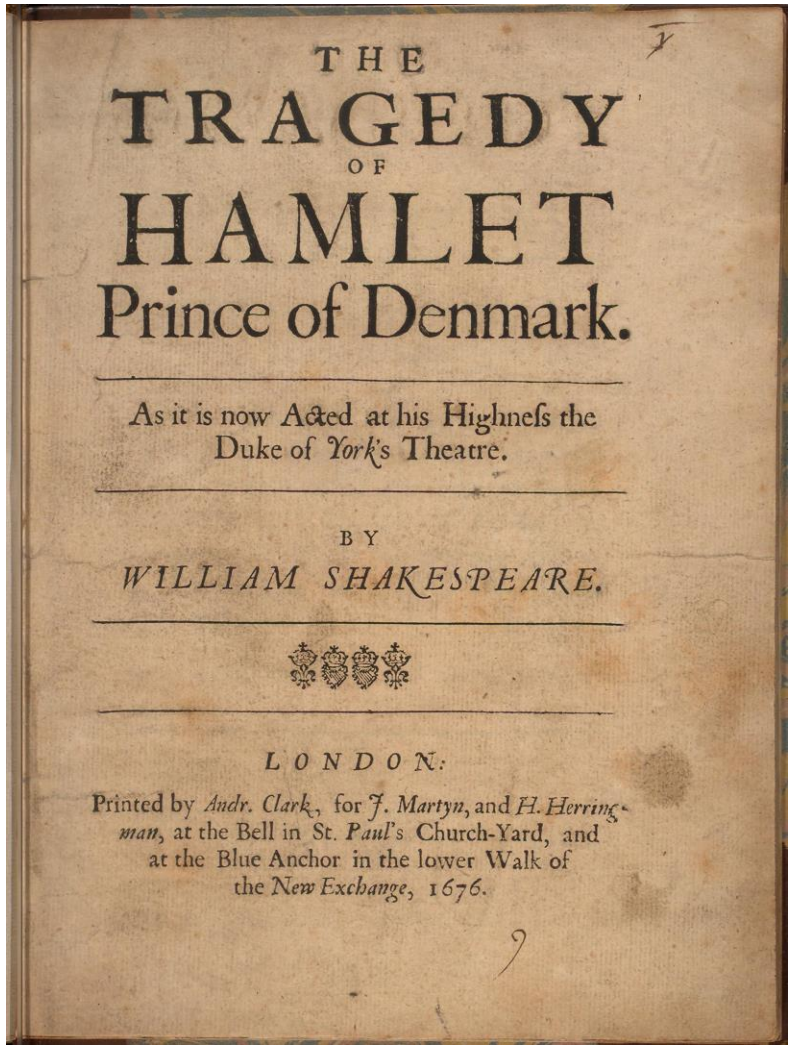
BJC British Journal of Cancer
www.nature.com/bjc

REVIEW ARTICLE

Ductal carcinoma in situ: to treat or not to treat, that is the question

Maartje van Seijen[1], Esther H. Lips[1], Alastair M. Thompson[2], Serena Nik-Zainal[3], Andrew Futreal[4], E. Shelley Hwang[5], Ellen Verschuur[6], Joanna Lane[7], Jos Jonkers[1,8], Daniel W. Rea[9] and Jelle Wesseling[1,10,11] on behalf of the PRECISION team



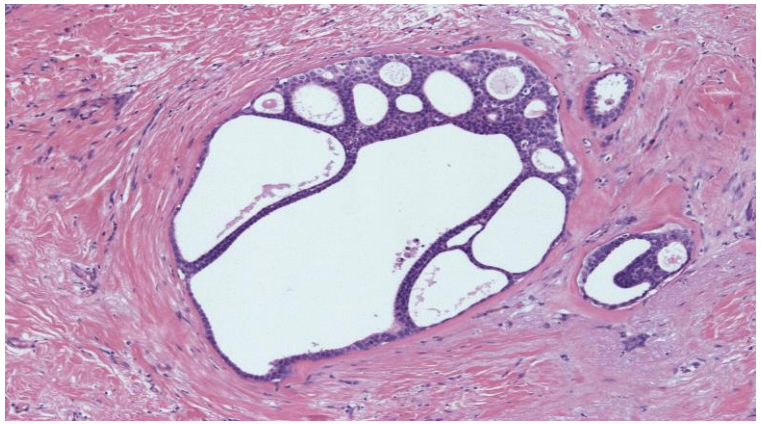


THE
TRAGEDY
OF
HAMLET
Prince of Denmark.

As it is now Acted at his Highness the Duke of York's Theatre.

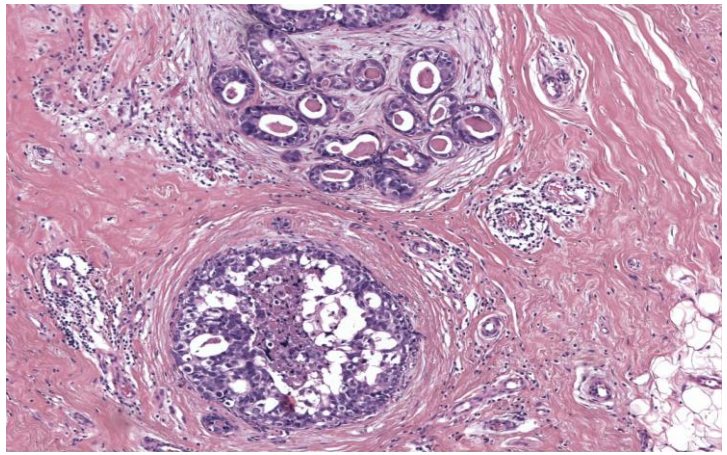
BY
WILLIAM SHAKESPEARE.

LONDON:
Printed by Andr. Clark, for J. Martyn, and H. Herringman, at the Bell in St. Paul's Church-Yard, and at the Blue Anchor in the lower Walk of the New Exchange, 1676.



Sono tutti uguali?

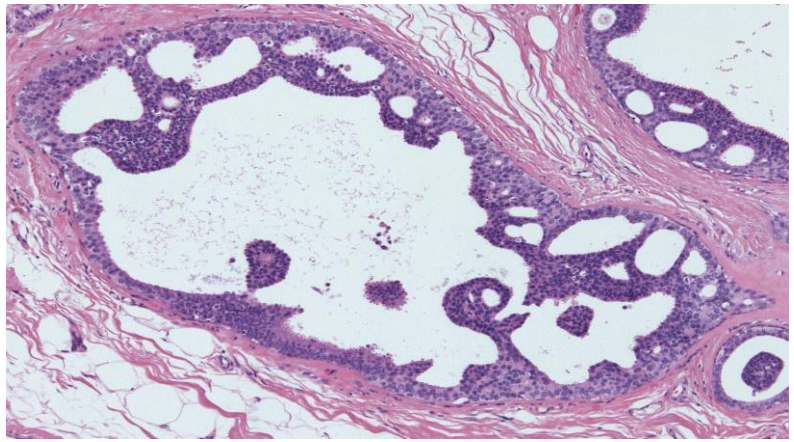
- Basso grado
- Alto grado



Quali ulteriori fattori da considerare?

- eta’ paziente, stato menopausale
- aspettativa di vita e comorbidità
- clinica

CDIS basso grado: omettere la chirurgia ?



original reports

Phase II Single-Arm Study of Preoperative Letrozole for Estrogen Receptor–Positive Postmenopausal Ductal Carcinoma In Situ: CALGB 40903 (Alliance)

E. Shelley Hwang, MD, MPH[1]; Terry Hyslop, PhD[1,2]; Laura H. Hendrix, MS[1,2]; Stephanie Duong, BA[3]; Isabelle Bedrosian, MD[4]; Elissa Price, MD[5]; Abigail Caudle, MS, MD[4]; Tina Hieken, MD[3]; Joseph Guenther, MD[6]; Clifford A. Hudis, MD[7]; Eric Winer, MD[8]; Alan P. Lyss, MD[9]; Diana Dickson-Witmer, MD[10]; Richard Hoefer, DO[11]; David W. Ollila, MD[12]; Timothy Hardman, BA[1]; Jeffrey Marks, PhD[1]; Yunn-Yi Chen, MD, PhD[5]; Gregor Krings, MD, PhD[5]; Laura Esserman, MD, MBA[5]; and Nola Hylton, MD[5]

- Letrozolo pre- ER+ 6m
- modificazione significative Rx (80%)
- **PCR 15% (75% basso grado)**

J Clin Oncol 38:1284-1292. © 2020 by American Society of Clinical Oncology

Virchows Archiv
https://doi.org/10.1007/s00428-021-03173-8

REVIEW

Low-risk DCIS. What is it? Observe or excise?

Sarah E. Pinder[1] · Alastair M. Thompson[2] · Jelle Wesserling[3]

Table 1 Design of surveillance trials for low-risk DCIS (*RCT* randomized control trial)

	LORIS	COMET	LORD	LORETTA
Country	UK	USA	Netherlands	Japan
Age	≥48	≥40	≥45	≥40, ≤75
Eligibility criteria	Low-grade DCIS or lower half of intermediate-grade DCIS*; no necrosis; vacuum-assisted biopsy* of screen-detected microcalcification required	Low- or intermediate-grade DCIS (or atypical ductal hyperplasia bordering on DCIS); initially no necrosis, but amended to be eligible; diagnosed on core, vacuum-assisted biopsy or surgical excision with positive margins, of microcalcification	Low-grade DCIS; amended to include low- and intermediate-grade DCIS; then amended to patient preference with additional criteria that should be ER positive and HER2 negative; vacuum-assisted biopsy of screen-detected microcalcification	Low- or intermediate-grade DCIS; no comedo-type necrosis; must be ER positive and HER2 negative; patients with findings other than calcification on mammography eligible
Design/standards of care	RCT/local care	RCT/guideline concordant	RCT/local care (see below)	Single arm
Endocrine therapy	Possible	Possible	Not allowed	Tamoxifen
Follow-up	10 years	2, 5, 7 years	10 years	5, 10 years
Opened	2014	2016	2017	2017
Target accrual; number to date	932; closed with 187 patients	1200 (900); 665	1240; closed and amended as patient preference	340; not known

*Protocol amendments were made to include as eligible those women with locally diagnosed low-grade DCIS that was considered by the review pathologists to represent atypical ductal hyperplasia and also those with surgical excision biopsy with positive margins

Ann Surg Oncol (2020) 27:4459–4465
https://doi.org/10.1245/s10434-020-08576-6

Annals of
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ORIGINAL ARTICLE – BREAST ONCOLOGY

Do Eligibility Criteria for Ductal Carcinoma In Situ (DCIS) Active Surveillance Trials Identify Patients at Low Risk for Upgrade to Invasive Carcinoma?

Tawakalitu O. Oseni, MD[1], Barbara L. Smith, MD, PhD, FACS[1], Constance D. Lehman, MD, PhD[2], Charmi A. Vijapura, MD[2], Niveditha Pinnamaneni, MD[2], and Manisha Bahl, MD, MPH[2]

TABLE 2 Patient demographics, ductal carcinoma in situ (DCIS) features, and surgical outcomes for the entire study cohort and for cases eligible for the COMET, LORD, and LORIS trials

	Entire cohort (n = 858) % (n)	COMET (n = 498) % (n)	LORD (n = 101) % (n)	LORIS (n = 343) % (n)
Patient demographics				
Mean age: years (range)	58 (28–89)	58 (40–87)	61 (45–87)	60 (46–87)
Race[a]				
White	91.3 (773/847)	90.8 (446/491)	91.7 (88/96)	92.3 (311/337)
African American	3.1 (26/847)	3.1 (15/491)	3.1 (3/96)	2.4 (8/337)
DCIS at biopsy				
Nuclear grade of DCIS				
Low grade	14.8 (127/858)	21.7 (108/498)	100.0 (101/101)	27.4 (94/343)
Intermediate grade	55.4 (475/858)	78.3 (390/498)	N/A	72.6 (249/343)
High grade	29.8 (256/858)	N/A	N/A	N/A
Receptor status of DCIS				
Estrogen receptor-positive	90.7 (778/858)	100.0 (498/498)	100.0 (101/101)	97.7 (335/343)
Progesterone receptor-positive[b]	81.1 (549/677)	92.3 (349/378)	97.3 (71/73)	88.9 (241/271)
Presence of comedonecrosis	31.1 (267/858)	25.7 (128/498)	5.0 (5/101)	0
Surgical outcomes				
Overall upgrade to invasive cancer	14.8 (127/858)	12.0 (60/498)	5.0 (5/101)	11.1 (38/343)
Mean size of invasive cancer: mm (range)	4.2 (0.2–22)	4.7 (0.2–20)	6.4 (2–12)	4.7 (0.5–20)
Microinvasive disease (≤ 1 mm)	35.4 (45/127)	25.0 (15/60)	0	31.6 (12/38)
Grade of invasive cancer[c]				
1	19.3 (21/109)	24.1 (13/54)	60.0 (3/5)	26.5 (9/34)
2	50.5 (55/109)	59.3 (32/54)	40.0 (2/5)	52.9 (18/34)
3	30.3 (33/109)	16.7 (9/54)	0	20.6 (7/34)
Receptor status of invasive cancer				
Estrogen receptor-positive[d]	86.5 (90/104)	94.4 (51/54)	100.0 (4/4)	88.2 (30/34)
Progesterone receptor-positive[e]	71.8 (74/103)	75.9 (41/54)	100.0 (4/4)	72.7 (24/33)
HER2-positive[f]	27.2 (28/103)	22.2 (12/54)	25.0 (1/4)	21.2 (7/33)
Positive nodal status of invasive cancer[g]	1.9 (2/105)	0 (0/45)	0 (0/3)	0 (0/29)

DCIS ductal carcinoma in situ; *HER2* human epidermal growth factor receptor 2

[a]Race unknown for 11 patients

[b]Progesterone receptor status unknown for 181 patients

[c]Grade unknown for 18 patients

[d]Estrogen receptor status unknown for 23 patients

[e]Progesterone receptor status unknown for 24 patients

[f]HER2 status unknown for 24 patients

[g]Sentinel lymph node biopsy not performed in 22 patients

Breast Cancer Research and Treatment (2021) 187:187–196
https://doi.org/10.1007/s10549-020-06042-1

EPIDEMIOLOGY

Treating (low-risk) DCIS patients: What can we learn from real-world cancer registry evidence?

Danalyn Byng[1,2] · Valesca P. Retèl[1,2] · Michael Schaapveld[1] · Jelle Wesseling[3] · Wim H. van Harten[1,2] on behalf of the Grand Challenge PRECISION consortium

Received: 16 October 2020 / Accepted: 28 November 2020 / Published online: 3 January 2021

Abstract

Purpose Results from active surveillance trials for ductal carcinoma in situ (DCIS) will not be available for > 10 years. A model based on real-world data (RWD) can demonstrate the comparative impact of non-intervention for women with low-risk features.

Methods Multi-state models were developed using Surveillance, Epidemiology, and End Results Program (SEER) data for three treatment strategies (no local treatment, breast conserving surgery [BCS], BCS + radiotherapy [RT]), and for women with DCIS low-risk features. Eligible cases included women aged ≥ 40 years, diagnosed with primary DCIS between 1992 and 2016. Five mutually exclusive health states were modelled: DCIS, ipsilateral invasive breast cancer (iIBC) ≤ 5 years and > 5 years post-DCIS diagnosis, contralateral IBC, death preceded by and death not preceded by IBC. Propensity score-weighted Cox models assessed effects of treatment, age, diagnosis year, grade, ER status, and race.

Results Data on $n = 85{,}982$ women were used. Increased risk of iIBC ≤ 5 years post-DCIS was demonstrated for ages 40–49 (Hazard ratio (HR) 1.86, 95% Confidence Interval (CI) 1.34–2.57 compared to age 50–69), grade 3 lesions (HR 1.42, 95%CI 1.05-1.91) compared to grade 2, lesion size ≥ 2 cm (HR 1.66, 95%CI 1.23–2.25), and Black race (HR 2.52, 95%CI 1.83–3.48 compared to White). According to the multi-state model, propensity score-matched women with low-risk features who had not died or experienced any subsequent breast event by 10 years, had a predicted probability of iIBC as first event of 3.02% for no local treatment, 1.66% for BCS, and 0.42% for BCS+RT.

Conclusion RWD from the SEER registry showed that women with primary DCIS and low-risk features demonstrate minimal differences by treatment strategy in experiencing subsequent breast events. There may be opportunity to de-escalate treatment for certain women with low-risk features: Hispanic and non-Hispanic white women aged 50–69 at diagnosis, with ER+, grade 1 + 2, < 2 cm DCIS lesions.

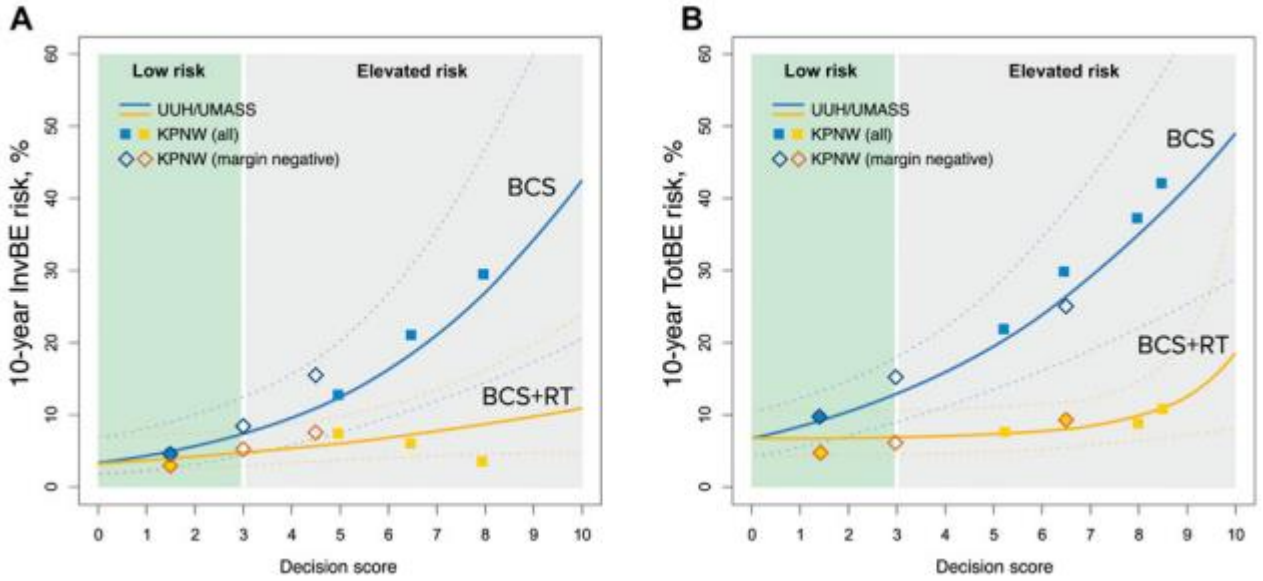
CDIS
…. Come migliorare il processo decisionale?

- **Definizione ottimale del profilo di rischio**
  - Rx/Patologo
  - Paziente ed ev. clinica
  - **Biomarkers molecolari**
    - Oncotype Dx CDIS
    - Decision Score

CLINICAL CANCER RESEARCH | PRECISION MEDICINE AND IMAGING

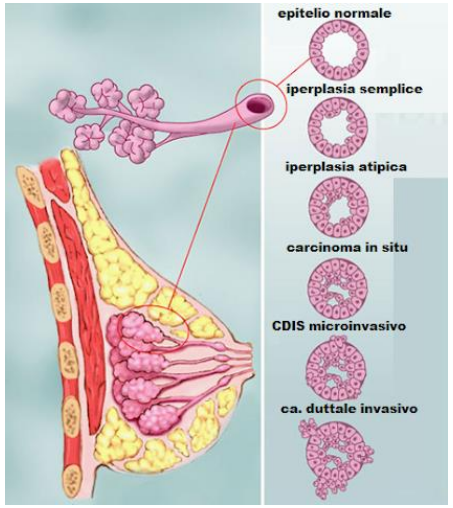
Validation of a Ductal Carcinoma *In Situ* Biomarker Profile for Risk of Recurrence after Breast-Conserving Surgery with and without Radiotherapy

Sheila Weinmann[1], Michael C. Leo[1], Melanie Francisco[1], Charisma L. Jenkins[1], Todd Barry[2], Glen Leesman[3], Steven P. Linke[3], Pat W. Whitworth[4], Rakesh Patel[5], James Pellicane[6], Fredrik Wärnberg[7], and



Bilancio costi/benefici

Le piccole lesioni dello screening



- **Carcinomi infiltranti**
  - T1a/b, N0, G1, Luminal A, Ki67< 10% («clearly low» – St. Gallen 2015) - 10%

Original Article

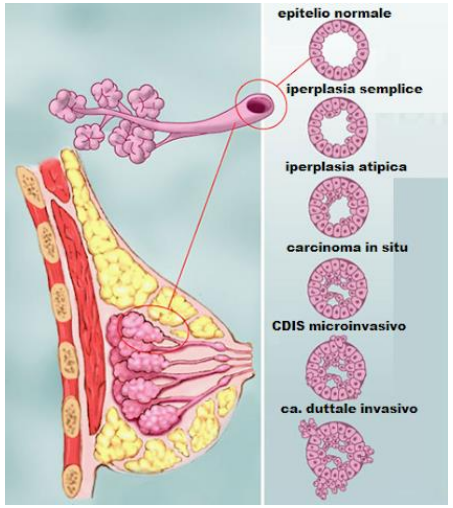
Detection and significance of small and low proliferation breast cancer

J Med Screen
0(0) 1–6

DOI: 10.1177/09691413211023970
journals.sagepub.com/home/msc
SAGE

Solveig Hofvind[1,2], Gøril Knutsvik[3,4], Åsne S Holen[1], Kaitlyn M Tsuruda[1,5] and Lars A Akslen[3,4]

Le piccole lesioni dello screening



- **Carcinomi infiltranti**
  - T1a/b, N0, G1, Luminal A, Ki67< 10% («clearly low» – St. Gallen 2015) - 10%

Original Article

Detection and significance of small and low proliferation breast cancer

J Med Screen
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SAGE

Solveig Hofvind[1,2], Gøril Knutsvik[3,4], Åsne S Holen[1], Kaitlyn M Tsuruda[1,5] and Lars A Akslen[3,4]

Le piccole lesioni dello screening

SPECIAL SERIES: LOCOREGIONAL MANAGEMENT OF BREAST CANCER

De-Escalation of Locoregional Therapy in Low-Risk Disease for DCIS and Early-Stage Invasive Cancer

E. Shelley Hwang, MD, MPH[1] and Lawrence Solin, MD[2†]

Hwang S., JCO 38:2230, 2021

- **Carcinomi infiltranti early**
  - setting chirurgia conservativa con **OMISSIONE Rxterapia p.o.**
  - de-escalation chirurgia ascellare ….. **OMISSIONE SLNB**

An Surg Oncol
https://doi.org/10.1245/s10434-021-10613-x

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

ASO AUTHOR REFLECTIONS

ASO Author Reflections: Overtreatment of Older Females with Favorable-Prognosis Breast Cancer

Jessica Thompson, MD[1], and Gerald P. Wright, MD[1,2,3]

[1]Spectrum Health/Michigan State University General Surgery Residency, Grand Rapids, MI [2]Spectrum Health Medical Group Comprehensive Breast Clinic, Grand Rapids, MI; [3]Division of Surgical Oncology, Spectrum Health Medical Group, Grand Rapids, MI

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Barriers and Facilitators to De-Implementation of the Choosing Wisely® Guidelines for Low-Value Breast Cancer Surgery

Margaret E. Smith, MD, MS[1,2], C. Ann Vitous, MA, MPH[2], Tasha Hughes, MD, MPH[1,2], Sarah P. Shubeck, MD, MS[1], Reshma Jagsi, MD, DPHil[3], Lesly A. Dossett, MD, MPH[1,2]

[1]Department of Surgery, University of Michigan, Ann Arbor, MI

[2]Center for Healthcare Outcomes and Policy, University of Michigan, Ann Arbor, MI

[3]Department of Radiation Oncology, University of Michigan, Ann Arbor, MI

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Annals of
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ASO AUTHOR REFLECTIONS

ASO Author Reflections: What will be Required to Safely Omit Breast Surgery for Early-Stage Breast Cancer?

Makoto Ishitobi, MD, PhD[1,2], and Naoki Hayashi, MD, PhD[3]

[1]Department of Breast and Endocrine Surgery, Osaka International Cancer Institute, Osaka, Japan; [2]Department of Breast Surgery, Mie University Hospital, Mie, Japan; [3]Department of Breast Surgical Oncology, St. Luke's International Hospital, Tokyo, Japan

- **! Falsi negativi**
- **! Accuratezza imaging**
- **! Appropriata quota di tessuto prelevato**

ORIGINAL ARTICLE ■ *Health Services Research and Policy*

Check for updates

Ductal Carcinoma In Situ Biology, Language, and Active Surveillance: A Survey of Breast Radiologists' Knowledge and Opinions

Lars J. Grimm, MD, MHS[a], Stamatia V. Destounis, MD[b], Habib Rahbar, MD[c], Mary Scott Soo, MD[a], Steven P. Poplack, MD[d]

Conclusions

Breast radiologists' opinions about DCIS biology, language, and active surveillance are not homogenous, but general trends exist that can be used to guide research, education, and advocacy efforts.

The Breast 54 (2020) 99–105

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Original article

Views of healthcare professionals about the role of active monitoring in the management of ductal carcinoma in situ (DCIS): Qualitative interview study

Check for updates

Brooke Nickel [a, b], Kirsten McCaffery [a, b], Nehmat Houssami [a], Jesse Jansen [a, b, c], Christobel Saunders [d], Andrew Spillane [e, f, g], Claudia Rutherford [h, i], Ann Dixon [a], Alexandra Barratt [a], Kirsty Stuart [j, k, l], Geraldine Robertson [m], Jolyn Hersch [a, b, *]

Conclusions: This study highlights the important need for robust randomised controlled trial data about active monitoring for women with low-risk DCIS, to provide HCPs with confidence in their management recommendations and decision-making.

Women's Awareness of and Responses to Messages About Breast Cancer Overdiagnosis and Overtreatment

Results From a 2016 National Survey

Rebekah H. Nagler, PhD, Erika Franklin Fowler, PhD,† and Sarah E. Gollust, PhD‡*

Results—Results showed that women's awareness of overdiagnosis (16.5%) and overtreatment (18.0%) was low, and women under age 40 were least likely to have heard about overdiagnosis. Most women did not evaluate statements about these harms positively: Fewer than 1 in 4 agreed with and found statements about overdiagnosis and overtreatment to be believable, and even fewer evaluated them as strong arguments to consider in their own mammography decision making. Women with a recent mammogram history were particularly unconvinced by overdiagnosis and overtreatment arguments.

original contribu

CARE DELIVERY ReCAP

Patient Preferences for Outcomes Following DCIS Management Strategies: A Discrete Choice Experiment

Brittany M. Chapman, BS[1]; Jui-Chen Yang, MEM[2]; Juan Marcos Gonzalez, PhD[2,3]; Laura Havrilesky, MD, MHSc[4]; Shelby D. Reed, PhD[2,3]; and E. Shelley Hwang, MD, MPH[5,6]

CONCLUSION Most women were willing to make some trade-offs between invasive cancer risk and treatment-related outcomes. Our findings highlight the importance of shared decision-making weighing risks and benefits between patient and provider management of low-risk disease.

Quando il trattamento diventa sovratrattamento

One size doesn’t fit all

! Definizione

- sicuri parametri di stratificazione rischio
- applicabilita’ di alternative terapeutiche

- **Condivisione scelte**
  - Team multidisciplinare
  - Paziente
    - Informazione costi/benefici
    - Personalizzazione strategia di cura

ASUGI
Azienda Sanitaria Universitaria Giuliano Isontina
REGIONE AUTONOMA FRIULI VENEZIA GIULIA

Breast Centres Certification
ITALCERT scheme in partnership with BCCERT
Certification n° 1632

Breast Unit Trieste